Health Services
LOS ANGELES COUNTY

November ~~3~~ 17, 2015

REVISED

ADOPTED

BOARD OF SUPERVISORS
COUNTY OF LOS ANGELES

18 November 17, 2015

PATRICK OGAWA
ACTING EXECUTIVE OFFICER

The Honorable Board of Supervisors
County of Los Angeles
383 Kenneth Hahn Hall of Administration
500 West Temple Street
Los Angeles, CA 90012

Dear Supervisors:

APPROVAL TO AMEND MY HEALTH LA AGREEMENTS
(ALL SUPERVISORIAL DISTRICTS)
(3 VOTES)

SUBJECT

Request approval to amend the My Health LA Agreements and Dental Care Services Agreement to implement programmatic and administrative changes, and terminate for default a My Health LA agreement.

IT IS RECOMMENDED THAT THE BOARD:

1. Authorize the Director of Health Services (Director), or his designee, to execute amendments to a) current My Health LA (MHLA) Agreements with the Community Partners (CPs), and b) the Dental Care Services Agreement with Children's Dental Foundation (CDF), listed in Attachment A, effective upon date of execution, through June 30, 2019, to permit the Department of Health Services to implement programmatic and administrative changes, as detailed herein.

2. Authorize the Director, or his designee, to terminate for default Agreement No. 706212 for MHLA Program Services, between Universal Health Foundation and the County of Los Angeles.

3. Delegate authority to the Director, or his designee, to terminate MHLA Agreements in accordance with the MHLA Agreement termination provisions, if deemed necessary, subject to review and approval by County Counsel, and notification to your Board and the Chief Executive Office (CEO).

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To ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at DHS facilities and through collaboration with community and university partners.

PURPOSE/JUSTIFICATION OF RECOMMENDED ACTIONS

MHLA officially launched on October 1, 2014. As of September 30, 2015, ~~August 31, 2015~~, 12 ~~11~~ months into the program, over 135,284 ~~131,000~~ individuals are enrolled in MHLA – 93% ~~90%~~ of the maximum 146,000 enrollment. DHS has worked collaboratively with Community Clinic Association of Los Angeles County (CCALAC) and MHLA clinics on opportunities to enhance enrollment strategies in order to maximize program enrollment. Many of the proposed changes to the MHLA Agreement will allow for more enrollment locations, especially in high-need areas such as the skid row neighborhood of Los Angeles County.

MHLA and CDF Amendments

Approval of Recommendation No. 1 will allow the Director, or his designee, to execute amendments, substantially similar to Exhibits I and II, to make administrative and programmatic changes that go beyond the scope of the delegated authority approved by your Board on September 23, 2014. The recommended changes include:

- Revising MHLA Definitions:

  - "Eligible Person" – revises the definition to prepare for the exclusion of individuals age 0-18 from the MHLA program, no sooner than May 1, 2016~~5~~, effective upon the implementation of SB 75, which makes children 0-18 eligible for full scope Medi-Cal regardless of immigration status.

  - "Medical Home" – expands the definition to include Part Time Clinic Sites (operating less than 35 hours per week) as well as Mobile Clinics, so long as the Medical Home operates with a predictable, fixed, and reoccurring schedule. This change expands the number of enrollment sites by 21 new locations where individuals can enroll in the MHLA program.

  - "Satellite Site" – revises the definition to delete language that requires a satellite site to be independently licensed in order to participate as a Medical Home in the MLHA program. The change allows 17 satellite sites to participate as a Medical Home in MHLA so long as they operate under the license of a parent clinic. This also expands the number of clinic sites that can enroll patients into the MHLA program.

- Revising Eligibility and Enrollment Requirements: The recommended changes further expand the number of sites where applications for enrollment into MHLA may be taken to include the newly defined Administrative Enrollment Sites, and adds Certified Application Counselors (CACs) as individuals who may take and

submit program applications. An Administrative Enrollment Site is a site that is not a Clinic Site, but is part of the Clinic's organization where the Clinic does eligibility determination and processes enrollments for health insurance (e.g., Medi-Cal, Covered California). An Administrative Enrollment Site must be a commercial or medical space, be open to the public, be open year-round, with a minimum of five (5) days per week, be welcome to walk-ins, and staffed with Certified Enrollment Counselors (CECs) and/or Certified Application Counselors (CACs). Administrative Enrollment Sites must also be fully equipped with all of the necessary equipment (e.g., computers/laptops with Internet access, printers, copiers, scanners, etc.) such that an enrollment at an Administrative Enrollment Site is the same as if the enrollment had taken place at the Medical Home.

- Revising the Health Care Options (HCO) Clinic Code Requirement for Adding New Clinic Sites: Clinics will now be able to demonstrate enrollment as a current, active provider in a Medi-Cal Managed Care program by producing verification from a Medi-Cal Managed Care HCO or contracted Health Plan, rather than having to possess a valid HCO Clinic Code number. This change will make it faster for Clinic Sites to be added to the MHLA network, as there is significant lag time for the State Medi-Cal office to issue HCO codes to clinics that have been approved by health plans to see patients.

- Revising Age Limits for Licensing and Credentialing, and Health Professional and Clinic Site Requirements: Amends the definition of a child from age 16 to age 21 for contractors that provide pediatric Primary Health Care Services to MHLA children and who are Child Health and Disability Prevention Program (CHDPP) approved, in order to mirror the State's definition of a child under the CHDPP program.

- Revising Redetermination/Re-Enrollment: The recommended change simplifies the renewal process to allow one adult MHLA Participant in a household to renew on behalf of everyone in that household, so long as all required documentation (i.e. proof of income, proof of residency) is provided for every member of the household. The Department proposes to make this change in order to simplify the renewal process for families and increase the renewal rate of the program.

- Revising Pharmacy Provisions: This recommendation makes changes to MHLA Pharmacy Phase II consistent with the use of clinic dispensaries and retention of a Pharmacy Services Administrator (PSA), including:

  - Requiring only those CPs who intend to utilize the DHS Central Pharmacy to fill 340B pharmaceuticals to register the DHS Central Pharmacy with HRSA and enter into a 340B Agreement with the County.
  - Authorizing the use of onsite dispensaries by CPs in Pharmacy Phase II so long as the dispensary has a valid State Board of Pharmacy permit, meets all State

regulations for drug dispensing, and submits daily (within 24 hours) dispensing data to the PSA.

- Establishing pharmaceutical reimbursement rates including an administrative fee for onsite dispensaries contingent upon submission of daily (within 24 hours) medication dispensing data to the PSA, and describes obligations of Contractors to participate in the Patient Assistance Program (PAP)

- Consistent with Business and Professions Code 4170 (a) (7), obligating the prescriber to provide all MHLA Participants with written disclosure that the Participant has a choice between obtaining the prescription from the dispensing prescriber or obtaining the prescription at a network pharmacy of the patient's choice.

- Adding a new Exhibit B.3 - "Monthly Grant Funding and Encounter Data Submission": Clarifies the obligations of CPs to submit monthly Encounter Data within 60 days to the Department on behalf of enrolled MHLA Participants who received a service

- Revising Dental Care Services: The recommended change removes Dental Care Provider's maximum dental allocation and therefore eliminates the Request for Information (RFI) process for dental fund reallocations, and revises dental claims submission deadlines. The Department proposes to eliminate from MHLA maximum allocations attached to the type of service being provided by CPs, so that there is no longer a $5 million cap on dental care services so long as those services remain within the $61 million appropriated for the MHLA program.

The recommended changes to the CDF Agreement outlined in Exhibit II, include only revised definitions for "Dental Care Services" and "Eligible Person", revisions to Agreement Paragraph 5.0, Billing and Payment, and the addition of Exhibit B-1, Dental Care Services, Billing, and Payment, that removes the maximum dental allocation, eliminates the RFI process for dental fund reallocations, and revises dental claims submission deadlines.

Termination of MHLA Agreements

Approval of Recommendation No. 2 will allow the Director, or his designee, to terminate for default Agreement No. 706212 for MHLA Program Services with Universal Health Foundation (UHF) due to non-compliance with the terms and obligations assumed under the Agreement. On September 23, 2015, UHF was sent a Notice of Suspension by the Director as a result of the contractor's ongoing failure to comply with administrative and patient care-related provisions of the MHLA Agreement. Over the course of the last year, UHF has continued to be non-responsive to requests by the Department to come into compliance with the MHLA Agreement. To date, none of the compliance issues have been resolved or remedied by UHF. Their contract has been suspended effective September 30, 2015, and the Department is seeking a termination of this Agreement for default.

Approval of Recommendation No. 3 will authorize the Department to terminate MHLA Agreements in accordance with the MHLA Agreement termination provisions following due

consideration, approval by County Counsel, and notification to your Board and the CEO. On rare occasions, MHLA contracted clinics have been deemed to be critically non-compliant with essential and often numerous components of the MHLA Agreement, often in areas that directly affect the quality and safety of patient care. In those instances where the Department has taken good faith and reasonable measures to bring the clinic into contract compliance without success, the Department seeks the ability to terminate the Agreement with that contractor without delay.

Implementation of Strategic Plan Goals

The recommended actions support Goal 1, Operational Effectiveness/Fiscal Sustainability, and Goal 3, Integrated Services Delivery of the County's Strategic Plan.

FISCAL IMPACT/FINANCING

Funding for the MHLA Program in the amount of $61 Million is included in the DHS Fiscal Year (FY) 2015-16 Final Budget and will be requested in future fiscal years, as needed.

FACTS AND PROVISIONS/LEGAL REQUIREMENTS

On September 23, 2014, your Board approved MHLA Agreements with an initial group of qualified and conditionally qualified CPs as a result of a Request for Statement of Qualifications (RFSQ) process. Your Board also approved a sole source successor Dental Care Services Agreement with Children's Dental Foundation. These agreements replaced previous Public-Private Partnership agreements, HWLA, and SB474 contracts.

On November 18, 2014, the Board approved additional MHLA Agreements with CPs that qualified as a result of a second RFSQ process.

County Counsel has reviewed and approved Exhibit I – the MHLA Amendment format and Exhibit II – Dental Care Services Amendment format, as to form.

CONTRACTING PROCESS

Not applicable.

IMPACT ON CURRENT SERVICES (OR PROJECTS)

Approval of the recommendations will allow DHS to make programmatic and administrative changes to the MHLA Agreements and Dental Care Services Agreement

aimed at improving the MHLA program for all stakeholders, including the patients who obtain services through the MHLA Program.

Respectfully submitted,

Mitchell H. Katz, M.D.
Director

MHK:pps

Enclosures (3)

c: Chief Executive Office
County Counsel
Executive Office, Board of Supervisors

MHLA - CORPORATE NAMES AND CONTRACT NUMBERS

	MY HEALTH LA, CONTRACTOR:	MHLA CONTRACT NO.:
1.	ALL FOR HEALTH, HEALTH FOR ALL, INC.	H-706170
2	ALL-INCLUSIVE COMMUNITY HEALTH CENTER	H-706171
3	ALTAMED HEALTH SERVICES CORPORATION	H-706172
4	ANTELOPE VALLEY COMMUNITY CLINIC	H-706173
5	APLA HEALTH & WELLNESS	H-706448
6	ARROYO VISTA FAMILY HEALTH FOUNDATION	H-706174
7	ASIAN PACIFIC HEALTH CARE VENTURE, INC.	H-706175
8	BARTZ-ALTADONNA COMMUNITY HEALTH CENTER	H-706176
9	BENEVOLENCE INDUSTRIES INCORPORATED	H-706177
10	BIENVENIDOS COMMUNITY HEALTH CENTER	H-706178
11	CENTRAL CITY COMMUNITY HEALTH CENTER, INC.	H-706179
12	CENTRAL NEIGHBORHOOD HEALTH FOUNDATION	H-706180
13	CHINATOWN SERVICE CENTER	H-706181
14	CHILDREN'S DENTAL FOUNDATION (Dental Services Agreement)	H-706240
15	CLINICA MSR. OSCAR A. ROMERO	H-706362
16	COMMUNITY HEALTH ALLIANCE OF PASADENA	H-706182
17	COMPLETE CARE COMMUNITY HEALTH CENTER, INC.	H-706183
18	COMPREHENSIVE COMMUNITY HEALTH CENTERS, INC.	H-706184
19	EAST VALLEY COMMUNITY HEALTH CENTER, INC.	H-706185
20	EL PROYECTO DEL BARRIO, INC.	H-706186
21	FAMILY HEALTH CARE CENTERS OF GREATER LOS ANGELES, INC.	H-706187
22	GARFIELD HEALTH CENTER	H-706188
23	HARBOR COMMUNITY CLINIC	H-706189
24	HERALD CHRISTIAN HEALTH CENTER	H-706190
25	JWCH INSTITUTE, INC.	H-706191
26	KEDREN COMMUNITY HEALTH CENTER, INC.	H-706192
27	KOREAN HEALTH, EDUCATION, INFORMATION AND RESEARCH CENTER	H-706193

MHLA - CORPORATE NAMES AND CONTRACT NUMBERS

	MY HEALTH LA, CONTRACTOR:	MHLA CONTRACT NO.:
28	LOS ANGELES CHRISTIAN HEALTH CENTERS	H-706194
29	LOS ANGELES LGBT CENTER	H-706195
30	MISSION CITY COMMUNITY NETWORK, INC.	H-706196
31	NORTHEAST VALLEY HEALTH CORPORATION	H-706197
32	PEDIATRIC & FAMILY MEDICAL CENTER, DBA EISNER PEDIATRIC & FAMILY MEDICAL CENTER	H-706198
33	POMONA COMMUNITY HEALTH CENTER	H-706199
34	QUEENSCARE HEALTH CENTERS	H-706200
35	SAMUEL DIXON FAMILY HEALTH CENTER, INC.	H-706201
36	SOUTH BAY FAMILY HEALTH CARE	H-706202
37	SOUTH CENTRAL FAMILY HEALTH CENTER	H-706364
38	SOUTHERN CALIFORNIA MEDICAL CENTER, INC.	H-706203
39	ST. JOHN'S WELL CHILD AND FAMILY CENTER, INC.	H-706204
40	THE CLINIC, INC.	H-706205
41	TARZANA TREATMENT CENTERS, INC. (Non-FQHC)	H-706206
42	THE ACHIEVABLE FOUNDATION	H-706207
43	THE CHILDREN'S CLINIC 'SERVING CHILDREN AND THEIR FAMILIES'	H-706208
44	THE LOS ANGELES FREE CLINIC, DBA SABAN COMMUNITY CLINIC	H-706209
45	THE NORTHEAST COMMUNITY CLINIC	H-706210
46	UNIVERSAL COMMUNITY HEALTH CENTER	H-706211
47	UNIVERSITY MUSLIM MEDICAL ASSOCIATION, INC.	H-706213
48	VALLEY COMMUNITY HEALTHCARE	H-706214
49	VENICE FAMILY CLINIC	H-706215
50	WATTS HEALTHCARE CORPORATION	H-706216
51	WESTSIDE FAMILY HEALTH CENTER	H-706217
52	WILMINGTON COMMUNITY CLINIC	H-706218

EXHIBIT I

Agreement No. H-_____

MY HEALTH LA PROGRAM SERVICES

AMENDMENT NO. __

THIS AMENDMENT is made and entered into this _____ day of _____, 2015,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and

_____ (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "MY HEALTH LA PROGRAM SERVICES", dated _____, 2014, and any amendments thereto, all further identified as Agreement No. H-_____ (all hereafter "Agreement"); and

WHEREAS, it is the intent of the parties to amend the Agreement to make programmatic and administrative changes needed for the continued implementation of the My Health LA Program; and

WHEREAS, County desires to address these necessary changes by making revisions to MHLA Agreement Paragraph 2.0, Definitions; and adding Agreement Exhibit A-1, Statement of Work; Exhibit B.3, My Health LA Program Monthly Grant Funding, Billing, and Encounter Data Submission; and Exhibit K-1(K-2), My Health LA Dental Care Services, Description of Services, Funding, Billing, and Payment; and

WHEREAS, the Agreement provides that changes to its terms may be made in the form of a written amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties hereby agree as follows:

1. This Amendment shall be effective upon execution.

2. Agreement Paragraph 2.0, Definitions, is hereby deleted in its entirety and replaced as follows:

"**2.0 DEFINITIONS**

The headings herein contained are for convenience and reference only and are not intended to define the scope of any provision thereof. The

following words as used herein shall be construed to have the following meaning, unless otherwise apparent from the context in which they are used.

2.1 **Active Contractor** identifies a Qualified Contractor who is in compliance with the terms and conditions of this Agreement and whose evidence of insurance requirements have all been received by the Department and are valid and in effect at the time the Agreement is executed. As used herein, the terms Active Contractor and Contractor may be used interchangeably throughout this document.

2.2 **Administrative Enrollment Site** means a site that is not a Clinic Site, but is part of the Clinic's organization where the Clinic does eligibility determination and processes enrollments for health insurance (e.g., Medi-Cal, Covered California). An Administrative Enrollment Site must be a commercial or medical space, be open to the public, be open year-round, with a minimum of five (5) days per week, be welcome to walk-ins, and staffed with Certified Enrollment Counselors (CECs) and/or Certified Application Counselors (CACs). To be an Administrative Enrollment Site, the site must adhere to any and all provisions of the Agreement, Provider Bulletins, and/or Provider Information Notices issued by the Department related to eligibility, and disposition and enrollment of Eligible Persons into the Program, including but not limited to the submission of complete required documentation using the MHLA Enrollment System. The Administrative Enrollment Site must be fully equipped with all necessary equipment (e.g., computers/laptops with Internet access, printers, copiers, scanners, etc.) such that an enrollment at an Administrative Enrollment Site will be processed in the same manner as if the enrollment had taken place and was processed at the Medical Home.

2.3 **Agreement** is County's standard agreement executed between County and individual Contractors. It sets forth the terms and conditions for the issuance and performance of the Statement of Work, Exhibits A and A-1.

2.4 **Ancillary Services** is limited solely to laboratory and basic radiology services (such as screening mammogram or chest x-rays).

2.5 **Care Coordination** is service which facilitates a patient's access to preventive, primary, specialty, behavioral health, or chronic illness treatment, as appropriate. Care Coordination may include such activities as: (a) an intake assessment of each

new patient's general health status, (b) referrals to qualified professionals, community resources, or other agencies as needed, (c) facilitating communication among patient's health care providers and (d) care management, case management, and transitions among levels of care, if needed.

2.6 **Children's School Health Clinic** means a Clinic Site located on a school campus which provides most of its Primary Health Care Services to youth who are age 18 and younger, generally orients its services to youth in the school, and is generally open only during the school's hours.

2.7 **Clinic** means the Contractor.

2.8 **Clinic Site** means a permanent location which is licensed to a Contractor, or is operated by a Contractor and is exempt from licensure under Cal. Health & Safety Code Section 1206, and is within Contractor's scope of project for purposes of FQHC certification, except for Clinic Sites located in SPA 1, at which some or all of the Included Services are provided.

2.9 **Co-located or Takeover Clinic Site** means Contractor has been given exclusive use of County-owned or leased property.

2.10 **Community Based School Health Clinic** means a licensed Clinic Site located on a school campus that provides Primary Health Care Services to both adults and youth, generally orients its service to the greater community, is open at least thirty-five (35) hours per week, and is open outside the school's hours.

2.11 **Confidential Information** includes: (a) Protected Health Information, consistent with the Health Insurance Portability and Accountability Act, the Health Information Technology for Economic and Clinical Health Act, and the regulations promulgated thereunder; (b) personal information concerning the Department, Contractors, or Health Professionals; (c) provider-specific information related to credentialing proceedings, quality reviews, final actions in connection with malpractice suits, and other information protected as peer-review material; and (d) proprietary business information, trade secrets and non-public financial information concerning the Department, Contractors or Health Professionals.

2.12 **Contractor Project Manager** is the individual designated by Contractor to administer the Agreement operations after the Agreement award.

2.13 **County Agreement Program Director** is the person designated by Director with authority to negotiate and recommend all changes on behalf of County.

2.14 **County Project Director** is the person designated by Director with authority for County on administrative matters related to this Agreement that cannot be resolved by the County Project Manager.

2.15 **County Project Manager** is the person designated as chief contact person with respect to the day-to-day administration of the Agreement.

2.16 **Day(s)** are calendar day(s) unless otherwise specified.

2.17 **Dental Care Services** means medically necessary and preventive outpatient dental care services for the prevention, detection, and treatment of dental problems and includes dental support services, charting to dental records, administrative management and pharmaceutical services or supplies, prescription medications and over the counter medications required in conjunction with Dental Care Services. Dental Care Services shall be limited only to those dental visit codes and procedures allowed by the State of California's Denti-Cal Program on the date of service, except those codes which require prior authorization or are restricted. Such codes requiring prior authorizations or which are restricted are not covered by the Program except for those listed on Exhibit K-1 and K-2, as applicable, MHLA Dental Care Services - Attachment I.

2.18 **DHS or Department** is County's Department of Health Services.

2.19 **DHS Facility** includes Medical Centers, Health Centers, or Ambulatory Care Centers all within Department of Health Services.

2.20 **Director** is the Director of the Department of Health Services or his/her authorized designee.

2.21 **Eligible Dispensary** means an on-site dispensary with a valid State Board of Pharmacy permit to dispense pharmaceuticals, that meets all State regulations for clinic medication dispensing and has the ability to submit daily (within 24 hours of dispensing) dispensing data in a format determined by the Department.

2.22 **Eligible Person** is defined as a person who meets all of the following:

a. Has been deemed ineligible for local, State and Federal full-scope (share of cost and no-share of cost) government healthcare program based on data entered by Contractor's Staff in the Enrollment System, or has provided written proof of denial (excluding denials related to failure to cooperate) from other state and Federal full-scope programs, which denial is dated within the thirty (30) days prior to the person's submission of an application to participate in the Program. Full-scope program includes any program that provides or funds the same scope of primary health care in an outpatient setting as MHLA.

b. Lacks health insurance (i.e. is uninsured). Individuals with restricted or limited scope Medi-Cal may be considered eligible for services not covered under restricted or limited scope Medi-Cal.

c. Is a current Los Angeles County resident, with proof of Los Angeles County residency, and does not have an active I-94 form (i.e. is a refugee, is an asylee, or possesses a certification letter from the Office of Refugee Resettlement). Homeless applicants may provide verbal proof of Los Angeles County residency. An Eligible Person's family member who is a student attending school outside of Los Angeles County is considered a Los Angeles County resident if the student (1) is claimed as a dependent on the most recent Federal and State tax returns filed on behalf of a Los Angeles County resident, and (2) lives at least part of the year in Los Angeles County for any year in which he or she seeks participation in the Program.

d. Is age 6 or older (inclusive) until such time that the State of California implements Section 14007.2 of the Welfare and Institutions Code, at which time is age 19 or older (inclusive). An emancipated minor may apply for coverage on his or her own behalf if he or she is not living in the home of a birth or adoptive parent, a legal guardian, caretaker relative, foster parent, or stepparent.

e. Has a household income at or below 138 percent of the Federal Poverty Level published by the U.S. Department of Health and Human Services. The pre-tax income

calculation shall include all earned and unearned taxable income, as well as realized earnings from non-retirement-related liquid assets (i.e., dividends paid in an investment account).

2.23 **Emergency Medical Condition** means a medical illness, injury or condition manifesting itself by acute symptoms of such severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention would result in any of the following: (a) placing the patient's health (or in the case of a pregnant woman, the fetus' health) in serious jeopardy; (b) serious impairment of bodily functions; or (c) serious dysfunction of any bodily organ or part.

2.24 **Emergency Services** means medical screening, examination, and evaluation by a physician or, to the extent permitted by applicable law, by other appropriate personnel under the supervision of a physician to determine if an Emergency Medical Condition (including a psychiatric Emergency Medical Condition) or active labor exists, and if it does, the care, treatment, including, as necessary, surgery, by a physician or other appropriately licensed personnel to stabilize, relieve, or eliminate the Emergency Medical Condition, within the capability of the facility.

2.25 **Employee(s)** means a person who is working for the entity and meets the definition of an employee as established by The Internal Revenue Service. Unless expressly limited, the word "employee" includes all employees of the entity, including Health Professionals and others, and not just those providing services under this Agreement.

2.26 **Enrollment System** means the Department's web-based eligibility and enrollment system for the Program.

2.27 **Fiscal Year** designates the twelve (12) month period beginning July 1st and ending the following June 30th.

2.28 **Health Plan** refers to either or both of the Medi-Cal Managed Care Plans in Los Angeles County: Health Net Health Plan or L.A. Care Health Plan.

2.29 **Health Professional** means a person holding a license, certificate, or registration that authorizes the person to provide certain professional health care services in the State of California, and who is employed by or under contract with

Contractor to provide Included Services to Participants. Health Professionals include Primary Care Providers, nurses, laboratory technicians, social workers, nutritionists, diabetic educators, and any other health or social service providers.

2.30 Include, Includes, Included, or Including means included, but not limited to, unless otherwise specified.

2.31 Included Services means Primary Health Care Services and Ancillary Services.

2.32 Medical Home means the Clinic Site or Mobile Clinic selected by each Participant that a Participant intends to utilize as their regular source of Primary Health Care Services. To be a Medical Home, a Clinic Site or Mobile Clinic must provide Primary Health Care Services and meet the requirements in either a. or b. or c. below:

a. Operates no fewer than 35 hours per week ("Full Time Clinic Site"), including Community Based School Health Clinics, but not including Children's School Health Clinics; or

b. Operates less than 35 hours per week ("Part Time Clinic Site"), or is a Children's School Health Clinic, and (i) at a site that is independently licensed by the California Department of Public Health or operates under the license of an independently licensed site by the California Department of Public Health, (ii) has an operational electronic health records system that will allow the Staff of a Full Time Clinic Site to view in real time the medical records of Participants selecting the Part Time Clinic Site, and (iii) notifies all Participants who selected the Part Time Clinic Site or Children's School Health Clinic as their Medical Home, that they may receive Included Services at an affiliated Full Time Clinic Site, whenever the Part Time Clinic Site is closed.

c. Is a Mobile Clinic and provides Primary Health Care Services either (i) in accordance with a predictable, fixed and recurring monthly schedule that may include multiple physical locations; or (ii) at the same, single location such that the Mobile Clinic is the functional equivalent of a fixed location clinic during its operating hours.

The Medical Home:

a. Provides Included Services as defined.

b. Facilitates outreach to and communication with preventive, specialty, mental health, substance abuse and chronic illness providers, as appropriate.

c. Refers Participants to qualified, culturally and linguistically competent professionals, community resources or other agencies as needed.

d. Ensures Care Coordination and transitions or referrals among levels of care, if needed.

e. Uses clinical guidelines and other evidence-based medicine, when applicable, for treatment and the provision of a Participant's health care services and timing of clinical preventive services.

f. Focuses on continuous improvement in quality and safety of care.

g. Provides health information, education and support to Participants and, if appropriate, their families in a culturally and linguistically appropriate manner.

h. Provides timely access to qualified medical interpretation as assessed and appropriate for Participants with limited English proficiency.

2.33 **Medically Necessary** services or supplies are ones that meet the following criteria: a category of services required to be provided under this contract, and not specifically excluded, and recommended by the treating clinician to be (a) for the purpose of diagnosing or treating a medical condition; (b) the most appropriate supply or level of service, considering potential benefits and harm to the Participant, (c) not furnished primarily for the convenience of the Participant; (d) not required solely for custodial or comfort reasons, (e) consistent with Department policies and furnished in the most appropriate place of service; and (f) known to be effective and safe in improving health outcomes. For new treatments, services or supplies, effectiveness is determined by scientific evidence. For existing treatments, services or supplies, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion. The fact that a physician or other provider

may prescribe, order, recommend or approve a service, or supply does not, in itself, make it Medically Necessary. The Department shall have the final authority for determining whether a treatment, service or supply is Medically Necessary, in its sole discretion.

2.34 **Mobile Clinic** is a mobile unit, as that term is defined at Health and Safety Code section 1765.105.

2.35 **Monthly Grant Funding (MGF)** is a method of payment for Included Services in which Contractor is paid a fixed amount, on a monthly basis, for each Participant assigned to Contractor, without regard to the actual number or nature of Included Services provided to each Participant.

2.36 **Non-Included Services** are those health care services that are not Primary Health Care Services or Ancillary Services, or that fall within the definition of Primary Health Care Services or Ancillary services but are specifically excluded by the Department under the Program, and which a Clinic is not obligated to provide to a Participant. Non-Included Services Include Primary Health Care Services, Ancillary Services, and Pharmaceutical Services that are not Medically Necessary; Primary Health Care Services related to pregnancy (except the diagnosis of pregnancy); the treatment of alcohol or drug abuse; or family planning as further defined by the Department. Mental health services for persons who are persistently and seriously mentally ill are also Non-Included services. A non-exclusive list of exclusions is provided in the MHLA Program Reference Manual.

2.37 **Participant** is an Eligible Person who is participating in the Program and selects or is enrolled by one of the Clinics as his or her Medical Home at which he or she will receive Included Services.

2.38 **Patient Referral** is a process whereby an Eligible Person seen at a DHS Facility is referred to Contractor for the provision of Primary Health Care Services.

2.39 **Pharmacy Monthly Grant Funding (Pharmacy MGF)** is a method of payment for Pharmacy Services in which Contractor is paid a fixed amount, on a monthly basis, for each Participant assigned to Contractor, without regard to the actual number or nature of Pharmacy Services provided to each Participant.

2.40 **Pharmacy Services** means the provision of pharmaceutical agents and consultative services by a pharmacist with a focus on drug safety, effectiveness and health outcomes.

2.41 **Primary Care Provider** is a general practitioner, family practitioner, internist, obstetrician/gynecologist, pediatrician, nurse practitioner, certified nurse midwife or physician assistant who is employed by or has contracted with the Clinic to provide Included Services to Participants.

2.42 **Primary Health Care Services** means those services provided in an outpatient setting to Participants for the prevention, diagnosis, or treatment of illness or injury including health evaluations, health advice, therapeutic services, diagnostic services, routine and preventive services, health care maintenance, chronic disease management, immunizations, outreach, emergency first aid, information and referral services, health education, prescribing medicines and other related services.

2.43 **Program** is the My Health LA (MHLA) Program offered by the County of Los Angeles.

2.44 **Protected Health Information** means health information that identifies or could reasonably be used to identify an Eligible Person or Participant that: (a) is created by or received from a Health Professional, the Department, Contractor, or health care clearinghouse, or a health plan; and (b) relates to the past, present, or future physical or mental health or condition of an Eligible Person or Participant, the provision of health care to an Eligible Person or Participant, or the past, present or future payment for the provision of health care to an Eligible Person or Participant.

2.45 **Qualified Contractor** is a Contractor who has submitted a Statement of Qualifications (SOQ) in response to County's Request for Statement of Qualifications (RFSQ); has met the minimum qualifications listed in the RFSQ; and has an executed Agreement with the Department of Health Services.

2.46 **Request for Statement of Qualifications (RFSQ)** is a solicitation based on establishing a pool of Qualified Contractors to provide services through Agreements.

2.47 **Satellite Site** is a permanent clinical location, operated by a Clinic, that is open for services no more than 20 hours per week, and can either be independently licensed by the

California Department of Public Health or operate under the license of an independently licensed Clinic Site by the California Department of Public Health.

2.48 Service Deliverable means evidence that Contractor is providing Included Services and all of the other items set forth in the Agreement for the Program.

2.49 Specialty Care Provider is a physician other than a Primary Care Provider who provides specialty-related services to Participants on referral by a Primary Care Provider.

2.50 Staff means any person who is working at a Clinic or Clinic Site, or working for County, regardless of whether such individual is an Employee. Unless otherwise limited, staff includes all persons working at a Clinic or Clinic Site regardless of whether they are providing services under this Agreement.

2.51 Statement of Qualifications (SOQ) is a Vendor's response to an RFSQ.

2.52 Statement of Work (SOW) is a written description of tasks and/or deliverables desired by County."

3. Agreement Exhibit A-1 – STATEMENT OF WORK, including Attachment I – Minimum System Requirements for One-E-App, and Attachment II.A – Performance Requirements Summary (PRS) Chart, shall be added to the Agreement, attached hereto and incorporated herein by reference.

4. Agreement Exhibit B.3 – MY HEALTH LA PROGRAM, MONTHLY GRANT FUNDING, BILLING, AND ENCOUNTER DATA SUBMISSION, shall be added to the Agreement, attached hereto and incorporated herein by reference.

5. Agreement Exhibit K-1(K-2) – MY HEALTH LA DENTAL CARE SERVICES, DESCRIPTION OF SERVICES, FUNDING, BILLING. AND PAYMENT, including Attachment I – MHLA DENTAL APPROVED PRE-AUTHORIZATION CODES, and Attachment II – COMMUNITY PARTNERS ABILITY-TO-PAY PLAN APPLICATION, shall be added to the Agreement, attached hereto and incorporated herein by reference.

6. Except for the changes set forth hereinabove, Agreement shall not be changed in any other respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by its Director of Health Services, and Contractor has caused this Amendment to be executed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By_____
Mitchell H. Katz, M.D.
Director of Health Services

_____
Contractor

By_____
Signature

_____
Printed Name

Title_____
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
Mary C. Wickham
Interim County Counsel

By _____
Senior Deputy County Counsel

EXHIBIT A-1
STATEMENT OF WORK

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EXHIBIT A-1
STATEMENT OF WORK

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EXHIBIT A-1
STATEMENT OF WORK
MY HEALTH LA PROGRAM
(Effective _____, 2015)

I. Background: Summary of program and purpose

The Department of Health Services (the Department or DHS) endeavors to meet the health care needs of certain low-income, uninsured Los Angeles residents who will remain uninsured after implementation of the federal Affordable Care Act's individual health insurance mandate. These individuals are known as the residually uninsured. The Department's mission is to ensure access to high-quality, patient-centered, cost-effective health care to Los Angeles County residents through direct services at the Department's facilities and through collaboration with its community partners. In order to fulfill this mission, the Department seeks to enhance its partnership with community clinic providers which share a commitment to serve the health care needs of Los Angeles County's residually uninsured population in a way that encourages coordinated, whole-person care, similar to the services that have been provided to uninsured residents through the current Healthy Way LA (HWLA) Unmatched program. Consistent with this mission, the Department is re-designing the HWLA Unmatched program as the My Health LA (MHLA) program, and has identified long-term goals related to the delivery of services under the new access program. These goals include, but are not limited to:

- **Preserve Access to Care for Uninsured Patients:** Ensure preservation of a health care safety net delivery system comprised of the Department and its community partners for the estimated 400,000 Los Angeles County residents who will not be eligible for any health care coverage programs under the Affordable Care Act.

- **Encourage coordinated, whole-person care:** Encourage better health care coordination, continuity of care, and patient management within the primary care setting.

- **Payment Reform/Monthly Grant Funding:** Rationalize the payment system for community partners to encourage appropriate utilization and discourage unnecessary visits by providing Monthly Grant Funding as opposed to fee-for-service payment.

- **Improve Efficiency and Reduce Duplication:** Encourage collaboration among health clinics and providers, by among other things, improving data collection, developing performance measurements and tracking of health outcomes, to avoid unnecessary service duplication.

- **Simplify Administrative Systems:** Create a simplified administrative infrastructure that encourages efficiency, and an electronic eligibility determination and enrollment system (for enrollment, renewal and disenrollment) for individuals participating in the program.

The Department's intent is to work collaboratively with its partners to realize these goals. As such, the Department acknowledges that programmatic modifications, as described, require sufficient time to plan, test, and implement, and must be based on sound data.

The MHLA Agreements will provide the Department with an important opportunity to take these steps, in concert with its Contractors.

Terms used but not defined herein are defined in the Agreement for MHLA Program Services.

II. Program Services

1. **Health Care Services:** Contractor shall provide Primary Health Care Services and Care Coordination.

2. **Laboratory:** Contractor shall provide all Medically Necessary laboratory services related to Primary Health Care Services. As such, Contractor shall operate a full service laboratory or establish a formal subcontract agreement with a certified laboratory which will be reflected in the Site Profile. If Contractor performs any of the following nine laboratory tests on site, it must have a current Clinical Laboratory Improvement Act (CLIA) certification or exemption certificate: dip stick or tablet urinalysis; fecal occult blood; ovulation test using visual color comparison; urine pregnancy test using visual color comparison; Hemoglobin by copper sulfate non-automated; Spun micro hematocrit; Blood glucose using certain devices cleared by the U.S. Food and Drug Administration for home use; erythrocyte sedimentation rate non-automated; and automated hemoglobin. Lab testing beyond these services must meet any additional CLIA requirements and Contractor must have a CLIA certificate for them.

3. **Radiology:** Contractor shall provide basic radiology services that are within the scope of Ancillary Services. As such, Contractor shall operate a radiological unit or establish a formal subcontract agreement with a certified radiological entity which shall be reflected in the Site Profile. Radiological services that Contractor is not obligated to provide under the Program include ultrasound, invasive studies, CT or MRI scans, Doppler studies, and comparison views-extremity film. Contractor may refer Participants to Department for these non-obligated radiological services.

4. **Pharmacy:** Contractor shall provide or arrange for the provision of Pharmacy Services as follows:

   a. Pharmacy Phase One

      Pharmacy Phase One begins on the effective date of the Agreement and ends when MHLA implements a MHLA pharmacy network through a contracted Pharmacy Services Administrator. Upon implementation of the MHLA pharmacy network, Pharmacy Phase Two, described in Subsection b. below, shall begin.

      During Pharmacy Phase One, Contractor shall be responsible for providing or assuring the provision of all medically necessary pharmaceuticals related to conditions for which the Participant is receiving Included Services, and for paying for such pharmaceuticals. Before prescribing a pharmaceutical not listed on the MHLA Formulary, Contractor shall submit a prior authorization request to MHLA and obtain prior authorization approval for the non-formulary pharmaceutical. To fulfill these obligations, Contractor may use its clinic dispensary, a licensed

pharmacy owned and operated by Contractor, or any licensed retail pharmacy with which it has a relationship.

b. 340B Program Requirements

With the exception of Clinic Sites in SPA 1, in order to participate in MHLA, Contractor is required to have access to 340B drug pricing and be registered with the Health Resource Services Administration (HRSA) Office of Pharmacy Affairs (OPA) on the effective date of this Agreement. Contractor is required to register at least one MHLA contracted 340B pharmacy with HRSA OPA to dispense 340B pharmaceuticals to Participants. If Contractor intends to utilize the Los Angeles County Health Services' Central Pharmacy (the DHS Central Pharmacy) to dispense 340B pharmaceuticals to Participants, Contractor shall submit its registration to HRSA OPA during a HRSA open enrollment period. A Contractor who intends to utilize the DHS Central Pharmacy shall execute a three-party 340B contract pharmacy services agreement with the DHS Central Pharmacy, NPI 1417364811, and RX E-Fill Solutions Pharmacy, NPI 1366889362, who will label, package and ship 340B pharmaceuticals to the Participant and/or Contractor on behalf of the DHS Central Pharmacy. This 340B pharmacy services agreement will allow the DHS Central Pharmacy to process 340B medications prescribed by Contractor's Primary Care Providers and the RX E-Fill Solutions Pharmacy to dispense and mail these pharmaceuticals during Pharmacy Phase Two.

Contractor shall have the right to audit and inspect the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy, including any relevant subcontractor, in order to comply with HRSA's 340B contract pharmacy guidelines. Contractor shall have the right to terminate its agreement with the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy so long as Contractor can demonstrate to the Department's satisfaction that Contractor has contracted with an alternate pharmacy in the MHLA pharmacy network to dispense 340B priced pharmaceuticals, and may terminate at any time upon a showing of demonstrable evidence to the Department's satisfaction that such agreement jeopardizes Contractor's compliance with Federal 340B requirements, such that the agreement poses an existing risk to Contractor's 340B status; and only if the Department is unable to remove such jeopardy after a reasonable cure period through a corrective action plan.

c. Pharmacy Phase Two

During Pharmacy Phase Two, the Department shall contract with a Pharmacy Services Administrator (PSA) to facilitate the use of a contract pharmacy network for Participants. The PSA shall establish, in coordination with the Department, a MHLA Pharmacy Network of licensed pharmacies from which Participants can obtain all MHLA Formulary pharmaceuticals to be established pursuant to Section II.4.d. below. If Contractor intends to use an on-site dispensary to dispense pharmaceuticals to Participants, the dispensary shall be an Eligible Dispensary as that term is defined in Paragraph 2.0, Definitions, subparagraph 2.21, Eligible Dispensary, of Agreement. If a Clinic operates an on-site licensed pharmacy, or contracts with a licensed pharmacy, that pharmacy must contract with the PSA in order to be included in the MHLA pharmacy network and to dispense pharmaceuticals to Participants.

Pharmacy Phase Two begins at the conclusion of Pharmacy Phase One and remains in effect for the remainder of the Agreement's term including any renewal period if extended by the County. The Department shall give Contractor at least thirty (30) days advance written notice of the date upon which the Department anticipates Pharmacy Phase Two will commence.

During Pharmacy Phase Two, Contractor shall be responsible for providing prescriptions to Participants for medically necessary pharmaceuticals associated with conditions for which Participant is receiving Included Services in accordance with the MHLA Formulary, including obtaining any prior authorizations.

If Contractor operates an Eligible Dispensary, Contractor shall submit medication dispensing data to the PSA on a daily basis (within twenty-four [24] hours of dispensing) in a format determined by the Department. The required data fields and format for submission of daily medication dispensing data by onsite dispensaries shall be provided to Contractor with at least thirty (30) days advance written notice of the date upon which the Department anticipates Pharmacy Phase Two will commence. Contractor dispensing medications from an Eligible Dispensary shall be compensated for all MHLA Formulary and Prior Authorization approved pharmaceuticals provided to Participants, in accordance with the rates and terms established by the Department, contingent upon submission of the medication dispensing data to the PSA in the time frame described herein and in accordance with all data submission standards established by the Department.

For medications dispensed by an onsite State licensed pharmacy which is included in the MHLA pharmacy network, Contractor shall be paid either the current clinic wholesaler's 340B price and a dispensing fee, or four dollars ($4.00) for a thirty (30)-day supply for designated drugs, in accordance with the terms and conditions established directly between the onsite licensed pharmacy and the PSA. For medications dispensed by an Eligible Dispensary, Eligible Dispensary shall be paid a total flat fee of four dollars ($4.00) per thirty (30)-day supply of generic formulary agents. All other formulary prescription agents (with a 340B drug ingredient cost exceeding four dollars [$4.00] per thirty [30] days) or Prior Authorization approved non-formulary agents shall be paid the medication's 340B drug ingredient cost and an administrative fee of five dollars ($5.00). Drugs dispensed through a Patient Assistance Program (PAP) shall not be reimbursed. A Contractor dispensing pharmaceuticals from an Eligible Dispensary is required to submit all PAP applications for PAP drugs.

If Contractor intends to utilize the DHS Central Pharmacy to dispense 340B medications to Participants, Contractor shall enter into all necessary agreements with the PSA, the DHS Central Pharmacy, and the RX E-Fill Solutions Pharmacy, and take all other steps as are necessary to allow the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy to be included in Contractor's 340B pharmacy Network during Pharmacy Phase Two. During Pharmacy Phase Two, the Department will take reasonable steps to assure that the contracted PSA's processes and procedures will not jeopardize Contractor's participation in the Federal 340B drug program, and that such PSA and the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy shall make such records available and provide such other assistance as is necessary to allow Contractor to comply with its obligations under the Federal 340B drug program, including ensuring Contractor's

rights to audit and inspect the DHS Central Pharmacy and RX E-Fill Solutions Pharmacy.

Consistent with Business and Professions Code section 4170(a)(7), the prescriber shall provide the Participant with written disclosure that the Participant has a choice between obtaining the prescription from the Contractor's onsite pharmacy or Eligible Dispensary, or obtaining the prescription at a MHLA network pharmacy of the Participant's choice.

d. My Health LA Formulary

During both Pharmacy Phase One and Pharmacy Phase Two, the Department shall maintain on-line, a MHLA Formulary, which are approved medications. Contractor shall prescribe medications whenever possible using the MHLA Formulary. Non-formulary and restricted pharmaceuticals shall require prior authorization with approval prior to dispensing. Contractor must submit a prior authorization in advance of prescribing any pharmaceutical that does not adhere to dispensing guidelines set forth in the MHLA Formulary, or in notices from the Department. The Department shall provide determination of the prior authorization request no later than one (1) business day after it was submitted. The Program requires the use of generic products whenever possible, in accordance with applicable law and regulations.

The MHLA Formulary also shall set forth the maximum supply of any medication that may be dispensed at one time.

e. Non-Prescription Therapies

Contractors shall counsel Participants on non-prescription therapeutic interventions, for example exercise, weight loss, and smoking cessation.

f. Patient Assistance Programs

The MHLA Formulary also shall identify the pharmaceuticals for which pharmaceutical manufacturer PAPs are available for MHLA patients. PAP information may also be provided for non-formulary prior authorization approvals. During Pharmacy Phase One, Contractor shall submit, on behalf of all of its Participants, applications for any applicable PAPs. During Pharmacy Phase Two, if Contractor operates an onsite licensed pharmacy that is part of the MHLA pharmacy network, Contractor shall obtain all applicable, necessary information and submit to the Department for pharmacy PAP submissions. Eligible Dispensaries shall be responsible for submitting their own PAP applications for applicable pharmaceuticals.

5. **Specialty Care:** When all treatment options by the Contractor's Primary Care Provider are exhausted, and/or the Participant's condition requires treatment by a Specialty Care Provider, Contractor shall refer the Participant to the Department in accordance with the Department's referral guidelines. Contractor shall assure that all appropriate examinations and Ancillary Services are completed prior to the referral, and that the justification for the referral is noted in the Participant's medical record and included in the referral to the Department. If the Contractor uses non-physician

providers, the referral shall be reviewed and approved by a physician prior to being submitted.

Contractor shall utilize eConsult to initiate specialty referrals, provided that it has been implemented for the particular specialty at the time of the referral. Contractor shall not be responsible for non-obligated radiological tests, as defined in Section II.3 above, recommended by the eConsult Specialty Care Provider. If eConsult is unavailable for any reason, Contractor shall submit referrals through the Department's Referral Processing System. Contractor shall coordinate any and all follow-up care with the Participant once the Participant is repatriated to his or her Medical Home.

6. **Emergency Services, Hospital and Urgent Care:** Participants shall be instructed to go to a Facility, if possible, in the event the Participant experiences an Emergency Medical Condition or urgent care situation requiring care that is beyond the scope of Contractor's capabilities. Participants requiring same or next day appointments for Included Services shall not be referred to the Department's emergency department or urgent care clinics. Contractor shall establish a mechanism to inform Participants how to access Emergency Services.

7. **After-Hour Services:** Contractor shall establish an after-hours plan consisting of, at a minimum, an outgoing after-hours phone message for Participants calling a Clinic or Clinic Site that is closed, which message shall include: (a) instructions to call 911 if the Participant is in need of Emergency Services, and (b) instructions on what the Participant should do if he or she is in need of prescription medications or medical advice. Such instructions may include contacting a specific nurse advice line, after-hours Clinic Health Professional or Pharmacist, or contracted pharmacy, if applicable. The after-hours plan may not include a referral to a DHS Facility for the purposes of obtaining pharmaceuticals or outpatient services after hours. Once the Pharmacy Services Administrator's system is implemented, the after-hours plan shall be modified to include referral to the MHLA pharmacy network as appropriate.

8. **Dental Care Services:** If Contractor has Dental Care Services available at its Clinic Site, those services may be provided as an option to Participants in accordance with Exhibit K-1 (or K-2, as applicable), Dental Care Services Description of Services, Funding, Billing and Payment.

III. Contractor Requirements

A. Licensing and Credentialing, and Health Professional and Clinic Site Requirements

1. Contractor shall abide by all applicable Federal and State laws, licensing requirements, and locally prevailing professional health care standards of practice, and shall represent and warrant that each Health Professional who provides Included Services shall maintain a current, unrestricted license certificate or registration to practice his or her profession in California. Contractor may use a Health Professional with a restricted license after receiving prior written approval from Department, which shall give such approval at its sole discretion. Such approval may only be received after Contractor has submitted appropriate and complete information to the Department. Compliance with this provision includes

annual reporting of clinic data to the Office of Statewide Health Planning and Development (OSHPD).

2. Contractor shall assure that Primary Health Care Services are provided by Health Professionals, including non-physician medical practitioners, and are predominantly in the areas of general medicine, family practice, internal medicine, pediatrics, obstetrics or gynecology. Non-physician medical practitioners may include nurse practitioners, nurse midwives, and/or physician assistants who are supervised in accordance with established clinical guidelines and applicable State and Federal law. If Contractor utilizes nurse practitioners, nurse midwives, and/or physician assistants in the delivery of Included Services, Contractor shall have in effect standardized protocols and agreements signed by a supervising physician, and shall comply with any applicable limits on the number of non-physician medical practitioners that may be supervised by a single physician, imposed on Contractor by state law. Contractor shall employ or contract with sufficient numbers of Health Professionals to provide all medically necessary Primary Health Care Services required by Participants who have selected Contractor as their Medical Home.

3. Contractor shall have a credentialing program for its Health Professionals which adheres to the established health care industry credentialing standards and guidelines and shall disclose to the Department information and documents relating to credentials, qualifications, and performance of its employed and contracted Health Professionals upon request. The Department shall request such information only where necessary to defend itself or to verify that credentialing is actually occurring. In addition, the Department shall assist Contractor in maintaining all applicable peer review protections to the greatest extent possible.

4. Contractor shall notify the Department within one (1) business day if it knows, or reasonably should know, based on credentialing or re-credentialing, peer review, and any other related quality assurance activities conducted by Contractor that:

    a. The license of any Health Professional is suspended, revoked or restricted, in any manner that renders him or her unable to provide Included Services;

    b. Any Health Professional is the subject of final adverse legal settlements or judgments against him or her concerning his or her qualifications or competence to perform medical services;

    c. A report regarding any Health Professional is filed with the California Medical Board or National Practitioner Data Bank;

    d. There is any material change in any of the credentialing information that has been provided to the Department regarding any Health Professional; or

    e. Any Health Professional is subject to sanctions under the Medicare or Medi-Cal Programs.

5. Contractor shall ensure that any Health Professional, whose professional license is revoked, suspended or restricted in a manner that renders him or her unable to provide Program services shall not render service to Participants until the revocation, suspension or restriction has been removed or otherwise resolved.

6. Included Services delivered or pharmaceuticals prescribed to Participants shall follow evidence-based guidelines as appropriate to a Participant's medical condition as established by organizations including the Agency for Healthcare Quality and Research, National Quality Forum, U.S. Preventive Services Task Force, Centers for Disease Control.

7. In the event that Contractor provides pediatric Primary Health Care Services, Contractor must be Child Health and Disability Prevention Program (CHDPP) approved. Additionally, Internal Medicine and General Medicine practitioners who provide Primary Health Care and who see children twenty-one (21) years of age or younger shall be CHDPP-approved. Pediatricians and Family Practitioners who provide Primary Health Care and who see children twenty-one (21) years of age or younger should be CHDPP-approved but are not required to be so approved.

B. **Reporting Requirements and Protected Health Information**

1. **Health Professional Profile.** Contractor shall provide the Department with the information requested by the Department which is necessary for the Department to maintain a current detailed listing of Contractor's Health Professionals, at the time of contract execution and as requested by the Department. This information shall be included in the Clinic Health Professional Profile.

2. **Clinic Site and Capacity Profile.** Contractor shall provide the Department with information requested by the Department which is necessary for the Department to maintain a current listing of Contractor's Clinic Sites and Mobile Clinics, and the anticipated capacity of each to serve Participants, at the time this Agreement is executed and as requested by the Department. This information shall be included in the Clinic Site and Capacity Profile. To the extent possible, Contractor shall inform the Department of any changes in its Clinic Site and Capacity Profile no less than fourteen (14) calendar days prior to the change. In the case of unforeseen circumstances that have the effect of changing the previously reported information, Contractor shall inform the Department as soon as Contractor becomes aware of the circumstances and the changed information.

3. **Open/Closed Status.** Contractor shall report its open/closed status to the Department in accordance with Section III.H of this Statement of Work.

4. **Medical Encounter Data.** Contractor shall submit to the Department, on a monthly basis and beginning no later than April 1, 2015, utilization or medical encounter data provided in an File Transfer Protocol secure, Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliant format (such as the 837 Claim/Encounter file format), regarding the provision of Program Services to Participants. Medical encounter data shall be provided by Contractor to the Department for all Participants receiving Included Services, unless limited by the Department through written notice. Contractor shall report data from all service locations, including satellite, mobile, and school based clinics, and shall accurately indicate the site where services were provided.

   The Department will provide Contractor with all necessary template(s) for the electronic submission of HIPAA compliant medical encounter data to the Department. Medical encounter data shall be maintained and submitted in such detail, at such

time, and in such form as is reasonable and consistent with the Department's requirements, which shall be provided by written notice. If the Department's requirements should change, the Department will provide Contractor at least thirty (30) days to comply therewith.

The provision of timely medical encounter data by Contractor is a Service Deliverable such that the failure to provide such medical encounter data due in a particular month will result in the suspension of payment to be made during that month.

The Department intends to use medical encounter data to track utilization of services by Participants, make informed decisions about potential program changes, establish normative standards, establish/maintain quality of care standards, and improve linkages among Program providers and the Department. These activities will be coordinated with broader Department wide performance/quality improvement activities. As provided in Section III.K.1.e. below, the Department shall review encounter data for completeness, accuracy, and compliance with formatting and submission requirements. Contractors which are not submitting accurate and complete medical encounter data in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve data submission issues in a prompt manner, may, at the sole discretion of the Department, be subject to suspension in monthly payments until such time as all medical encounter data has been received and accepted by the Department.

5. **Improvement Programs.** Contractor shall participate in Program quality improvement programs and provider education programs based on these reporting requirements. The Department may, at its discretion and at some point in the future, develop a quality and/or clinical outcomes improvement program, which may or may not be tied to encounter data. The Department will provide notice to Contractors via Provider Information Notice (PIN) within sixty (60) days of implementing any quality and/or clinical outcomes improvement program.

6. **Secured Email Transmission.** Contractor and its Staff are required securely to send Confidential Information via encrypted email, in accordance with all applicable State and Federal laws and County policies and guidelines as it pertains to the electronic transmission of Protected Health Information.

7. **Program Enrollment Targets.** Simultaneously with contract execution, Contractor shall provide to the Department its Program enrollment targets for the first term of this Agreement which shall be based on Contractor's anticipated capacity for the Program. By June 30 of each subsequent year, Contractor shall provide its program enrollment targets for the next fiscal year. Contractor's progress toward meeting its annual enrollment targets will be monitored by the Department.

8. **Visit Information.** Beginning in November, 2014, and continuing through and including March, 2015, Contractor shall provide to the Department, in the form and manner defined by the Department, an accurate count of the number of visits provided in the preceding month to Participants. Such count shall include only visits provided to persons who were actually enrolled in MHLA by the close of business on the date of service. Such information shall be provided no later than the 15th of each month (or the next business day following the 15th of the month if

the 15th is a weekend day or holiday). Further, in the event that Contractor discovers any errors in the count of visits so reported, it shall immediately inform the Department and shall provide a corrected count as soon as it is known.

The parties agree that time is of the essence in receiving the visit count information, which shall be used to assure that expenditures for MHLA do not exceed the available appropriation for Fiscal Year 2014-2015. The parties further agree that it will be impracticable or extremely difficult to fix the extent of actual damages resulting from the failure of Contractor to submit its data on time. The parties hereby agree that under the current circumstances, a reasonable estimate of such assessment is one hundred dollars ($100) per day until the data is submitted and that the Contractor shall be liable to the County for the assessment in said amount. Said assessment amount shall be deducted from any payments owed by County to the Contractor. The payment of assessment shall not, in any manner, restrict or limit the County's right to damages for any other breach of this Contract provided by law or as specified in this Agreement.

C. **Payment Requirements**

1. Included Services.

   For the period October 1, 2014 through March 31, 2015, Contractor shall be paid for Included Services provided to Participants on a fee-for-service basis in accordance with Paragraph 5.1 of the Agreement and Exhibit B.1, Fee-For-Service Payment and Billing, of the Agreement. Beginning April 1, 2015, Contractor shall be paid Monthly Grant Funding (MGF) by the Department in accordance with Paragraph 5.2 of the Agreement and Exhibit B.3, My Health LA Program Monthly Grant Funding, Billing, and Encounter Data Submission. The MGF is based upon data collection and analysis undertaken by the Department. The fee-for-service rate and MGF are specified in Exhibit B.2, Pricing Schedule. The fee-for-service rate and the MGF cover only Included Services.

   The Department will monitor expenditures on a monthly basis. In the event that the Department determines that there will be insufficient appropriation to continue to fund MHLA through the end of Fiscal Year 2014-2015, assuming enrollment of 146,000 Participants, the Department may advance the start date of the MGF upon a thirty (30)-day advance written notice to Contractor.

2. Pharmacy Services.

   During the period in which Contractor is reimbursed for Included Services on a fee-for-service basis, Contractor shall not be compensated separately for the provision of Pharmacy Services.

   During Pharmacy Phase One, Contractor shall be paid Pharmacy MGF pursuant to the same terms and conditions, and using the same processes as the MGF, in accordance with subparagraph 5.3.2 of the Agreement.

   During Pharmacy Phase Two, payment for Pharmacy Services shall be managed by the Department's contract PSA, in accordance with subparagraph 5.3.3 of the Agreement and Section II.4 of this Statement of Work.

3. Dental Care Services.

   Contractor shall be paid for the provision of Dental Care Services on a fee-for-service basis, in accordance with Exhibit K-1 (or K-2, as applicable), Dental Care Services Description of Services, Funding, Billing, and Payment, of the Agreement.

4. Additional Conditions of Payment.

   As a condition of payment, Contractor shall meet all enrollment and re-enrollment requirements as defined in Subsections D. and E. below, and shall perform all Service Deliverables under the Agreement.

5. Contractor shall participate in the Medi-Cal Program and remain in good standing under that program for the entire term of the Agreement and shall maintain its status as a Federally Qualified Health Center (FQHC) or Federally Qualified Health Center Look-Alike (FQHC Look Alike), if applicable. Further, Contractor shall maintain all legally required licenses and/or certifications. Contractor shall have and maintain a Medi-Cal managed care contract with at least one of the Health Plans in the County of Los Angeles and shall maintain a Medi-Cal Managed Care or Department Facility Site Review score of 80 or better for each Clinic Site.

D. **Eligibility and Enrollment Requirements**

Contractor shall only enroll Eligible Persons as described herein.

Contractor shall enroll and re-enroll Participants into the Program through the Enrollment System. The Department will determine the Program eligibility rules to be used by the Enrollment System for the eligibility determination and application process. The Department shall provide Contractor a Program Eligibility Reference Manual, which contains detailed information regarding eligibility screening and enrollment. The Department shall provide on-going update and refresher training on eligibility and enrollment.

Applications for enrollment may only be taken and processed at Medical Homes, and at Administrative Enrollment Sites approved pursuant to Agreement Paragraph 2.0, Definitions, subparagraph 2.2, Administrative Enrollment Site, where the clinic processes enrollments for health insurance (e.g., Medicaid, Covered California).

Contractor shall utilize only Certified Application Assistors (CAAs), Certified Enrollment Counselors (CECs) and/or Certified Application Counselors (CACs), persons who have successfully completed the We've Got You Covered training, and/or any person who has met the training requirements specified by the Department in a PIN ("Qualified Enrollers") to take and submit Program applications according to Program rules. CAAs/CECs/CACs shall screen applicants for eligibility in Federal, State and other local health insurance programs. Contractor shall provide documentation demonstrating that persons performing enrollment have the required qualifications to be Qualified Enrollers. Program enrollment shall not occur when an applicant is found to have eligibility for, or be enrolled in, another health care insurance program, unless the program is one which the Department, at its sole discretion, has excluded from this provision.

Prior to April 1, 2015, only persons who have successfully completed One-E-App training from the Department or from a Department designated trainer, or who is a CAA, and who are or intend to become a CEC and/or CAC, or complete training from We've Got You Covered, may receive access to One-E-App and act as a Qualified Enroller.

Contractor shall comply with the technical requirements specified in Attachment I, Minimum System Requirements for One-e-App, to this Exhibit, and provide adequately trained staff to perform enrollment functions. Enrollment functions include, but are not limited to:

1. Screen and assist Eligible Persons with submitting applications for a variety of local, State and Federal health insurance programs, if preliminarily determined eligible;

2. Enroll Eligible Persons in the Program who are not qualified for other health care insurance programs;

3. Access data regarding Program enrollment status for Eligible and/or Enrolled Persons;

4. Modify existing applications;

5. Renew Participants as set forth in Subsection E. below;

6. Support enrollment/application system users.

Contractor shall (i) participate in all required Program trainings, (ii) designate an individual(s) who will serve in a lead role with respect to the Department's Enrollment System within Contractor's organization, and (iii) ensure that all Qualified Enrollers enrolling participants into the Program via the Enrollment System have either paper or electronic access to the System's Program Eligibility Reference Manual.

Qualified Enrollers handling enrollment shall use the Enrollment System to screen and assist Los Angeles County residents with referrals to other public health programs as applicable.

E. **Redetermination/Re-Enrollment**

Contractor shall make every effort to obtain a Program renewal application from the Participants who have selected Contractor. Failure to complete the renewal process prior to the end of the one-year enrollment period will result in the disenrollment of that Participant from the program. Contractor may renew Participant enrollment as early as ninety (90) days prior to the end of a Participant's enrollment period.

Contractor's Qualified Enrollers who are handling redetermination or re-enrollment shall conduct an in-person interview with at least one adult household member that is on the application for renewal or re-enrollment. If a Participant who was previously part of a household is no longer eligible to remain in that household upon renewal, that Participant must be present for their renewal. Contractor shall rescreen each Participant on the application for eligibility for other public programs and process the

renewal application for the Program, if still eligible, via the Enrollment System. Qualified Enrollers shall update the Participant's information, including re-submittal of all required documentation for each individual on the application who is renewing, in the Enrollment System to reflect new demographic information (e.g. change of address, income or assets), and/or any other change that may link the applicant to a different program (e.g. change in pregnancy status, citizenship or family size). The Enrollment System will retain all documents collected during the initial enrollment and re-enrollment. Permanent documents (e.g., documentation of identification) do not require re-submission at re-enrollment while temporary documents (e.g., documentation of income or residence) will require submission of updated and recent information. Detailed Program requirements shall be set forth in the Program Eligibility Reference Manual.

F. **Dis-enrollment**

Participants who no longer meet program eligibility requirements shall be dis-enrolled from the Program. Participants can voluntarily dis-enroll at any time. A former Participant can re-enroll into the Program after disenrollment if the individual meets the Program eligibility requirements.

If Contractor obtains information that indicates that a Participant no longer meets program eligibility requirements during his or her enrollment period, a dis-enrollment request shall immediately be initiated by Contractor. Contractor shall submit documentation (e.g., proof of enrollment in full-scope [share-of-cost and no-share-of-cost] health insurance, proof of non-Los Angeles County residence) to County which demonstrates that the participant no longer meets program eligibility requirements in a manner to be determined by the County.

Participants with full-scope active Medi-Cal Hospital Presumptive Eligibility shall not be dis-enrolled from the Program.

G. **Medical Home Selection**

Participants must select a Medical Home for Primary Health Care Services and will receive a printed enrollment approval notice displaying their selected Medical Home. Participants will be sent an identification card and welcome packet by the Department.

Except as specified below, Participants may change their Medical Home no more than once per year. Participants may change their Medical Home at the time of their annual renewal and may not change their Medical Home at any other time unless: (1) the Participant has moved or changed jobs, and is seeking a new Medical Home closer to his/her new place of residence or employment, (2) the Participant has a change in his/her clinical condition and is seeking a new Medical Home that he/she believes can better manage this medical condition, (3) the Participant has a deterioration in the relationship with the health care provider(s) at his/her Medical Home, or (4) the location of the Medical Home is closed temporarily or permanently. The Participant may change his or her Medical Home for any reason within the first thirty (30) days of enrollment in the Program. All Medical Home changes are effective the first day of the month following the request for change.

H. **Clinic Capacity, Open/Closed Status for New Enrollment, Access Standards**

Contractors will be surveyed a maximum of twice monthly by the Department to determine whether there are any changes to the Clinic's open/closed status based on their capacity. Response to this inquiry by the Department shall be considered a Service Deliverable. Capacity is defined by the number of days that a new Participant must wait before he or she can obtain a non-urgent Primary Health Care Services appointment at the Clinic Site. A Clinic Site is considered to have capacity if the Clinic Site could schedule a non-urgent Primary Health Care Services appointment within ninety (90) calendar days. A Clinic Site does not have capacity if the Clinic Site could not schedule a non-urgent Primary Health Care Services appointment within ninety (90) calendar days. A Clinic Site with capacity shall be considered "open" to new Participants. A Clinic Site without capacity shall be considered "closed" to new Participants.

Contractor shall make available to Participants same or next day appointments for Participants whose medical condition requires them to be seen outside of a scheduled appointment. Participants requiring same or next day appointments for Included Services shall not be referred to the Department's Emergency Department or Urgent Care clinics during the Clinic Site's hours of operation.

The open or closed status of a Clinic Site shall be entered by the Department into the Enrollment System and is information that shall be available to all Clinics.

Contractor shall inform the Department within twenty-four (24) hours if a Clinic Site no longer has the capacity to accept new Participants. Contractor shall notify the Department of its intent to reopen its Clinic to new Participants.

A Clinic Site's open or closed status will determine whether a Clinic Site is open to accept a referral of an Eligible Person from the Department. Any Clinic Site that is "open" to new Participants must be uniformly open to Eligible Persons regardless of whether the Eligible Person presents as a walk-in or is referred from the Department. Acceptance of Department-referred Eligible Persons to an "open" Clinic Site is a Service Deliverable. The Contractor shall not refuse to accept a Department-referred Eligible Person unless (1) the Clinic Site is "closed" to new Participants, or (2) the Clinic does not have the clinical capability to care for the Eligible Person, as determined by Contractor's physician who shall attest that the Contractor does not have the clinical capability to render appropriate care to the Eligible Person. Such attestation shall be in writing, signed by the physician, include a detailed explanation as to why care cannot be rendered and submitted to the Department within twenty-four (24) hours of the referral by the Department. The Department shall provide to Contractor the complete protocol for Patient Referral through a future Provider Information Notice (PIN) process.

A closure to new Eligible Persons must apply uniformly to all Eligible Persons. This means that a Clinic Site or Mobile Clinic may not be open to providing Primary Care Services to some new Eligible Persons, but not others. Clinic Sites and Mobile Clinics shall provide services to their existing Participants even if they are closed to new Eligible Persons. Contractor shall not close its practice to its existing Participants.

At no time shall Contractor be permitted to design or deploy programs in such a manner as to exclude or disadvantage Participants or to advantage patients with third-party payors or financial means.

I. **Deletion of Existing Approved Clinic, Mobile Clinic, or Administrative Enrollment Sites**

1. Contractor shall notify the Department consistent with Paragraph 8.38, Notices, of the Agreement at least ninety (90) days prior to the temporary or permanent closure of a Clinic Site, Mobile Clinic, and/or Administrative Enrollment Site.

2. Contractor shall provide at least sixty (60) days advance written notice of the pending closure to all Participants who have selected the closing Clinic Site as their Medical Home and shall obtain the Department's approval of this correspondence prior to sending it to the Participants. The Department will respond within five (5) business days with an approval or denial of the correspondence; otherwise Contractor may proceed.

3. In such notice, Participants shall be informed that they have no less than thirty (30) days to select a new Medical Home, which may be part of the same Contractor or may be under a different Contractor.

4. Contractor shall notify the Department of those Participants who do not select a new Medical Home, and shall notify the Department of nearby Clinic Sites who have expressed a willingness to accept those Participants.

5. Contractor shall provide this information to the Department at least thirty (30) days prior to the closure of the Clinic Site.

6. In the case of a closure due to an emergency or unforeseen circumstance (e.g., fire, flood), Contractor shall notify the Department and Participants of the closure as soon as feasibly possible, and shall make every effort to assist Participants with identifying a new Medical Home.

J. **Adding a New and/or Transferring a Clinic, Mobile Clinic, or Administrative Enrollment Site**

1. If a Contractor wishes to open a new or transfer a Clinic Site or Mobile Clinic during the duration of the Agreement, the new or transferred Clinic Site or Mobile Clinic shall meet the following criteria:

   a. Shall be operational.

   b. Shall demonstrate valid enrollment as a current, active provider in the State of California Medi-Cal Program.

   c. Shall demonstrate enrollment as a current, active provider in a Medi-Cal Managed Care program by producing verification from Medi-Cal Managed Care Health Care Option or contracted health plan (i.e., approval letter or paid claim for a Medi-Cal managed care patient from a Health Plan).

d. Shall possess at least one (1) NPI Number of the Clinic Site or Satellite Site.

e. Shall have completed and passed either the Department or the Health Plan's Facility Site Review (FSR) process.

f. Shall have an appropriate, current license issued by California Department of Public Health, or meets the requirements to be exempt from licensure under California Health & Safety Code Section 1206(h). Not applicable for the Satellite Sites operating under the license of a Clinic Site.

g. Shall be registered with, or must be able to demonstrate proof of submission to, the Office of Statewide Health Planning and Development (OSHPD) as an appropriately licensed clinic. Not applicable for the Satellite Sites operating under the license of a Clinic Site.

h. Shall be designated by the Centers for Medicare and Medicaid Services as a FQHC or a FQHC Look-Alike, and registered with HRSA Office of Pharmacy Affairs to access the 340B program, and register at least one MHLA contracted 340B pharmacy to dispense 340B pharmaceuticals to Participants. An exception to this requirement is any Clinic Site that is operating in SPA 1 (including **the communities of Acton, Agua Dulce, Gorman, Lake Hughes, Lake Los Angeles, Lancaster, Littlerock, Palmdale, Quartz Hill, and others)** which is not subject to the FQHC or FQHC Look-Alike requirement. All other qualification requirements apply to Clinic Sites in SPA 1. For a full map of the County's SPAs, refer to: http://publichealth.lacounty.gov/chs/SPAMain/ServicePlanningAreas.htm)

i. Shall certify that all of its physicians and/or mid-level nurse practitioners working at the new Clinic Site or Mobile Clinic meet the requirements in Section III.A above.

2. If a Contractor wishes to open a new Administrative Enrollment Site during the duration of the Agreement, the new Administrative Enrollment Site shall meet the following criteria:

a. Shall be operational.

b. Shall demonstrate compliance with all requirements of an Administrative Enrollment Site pursuant to Agreement Paragraph 2.0, Definitions, subparagraph 2.2, Administrative Enrollment Site.

c. Shall have a business license or rental agreement. If more than one entity is occupying shared space/co-location, the Administrative Enrollment Site entity must submit a Memorandum of Understanding.

K. **Medi-Cal Requirements and Departmental Record Reviews and Audits**

Contractor must have a Medi-Cal Managed Care contract with at least one of the Health Plans in the County of Los Angeles and must receive full-scope facility site and medical record reviews through their Health Plan contract(s) and/or the Department.

The Department shall review and may accept the Health Plan site and medical record review findings.

The Department has the right to audit or review any and all aspects of Contractor's performance related to this Agreement. In addition, the Department will conduct its own annual program monitoring, administrative and financial monitoring visits which include the following reviews.

1. **Program Monitoring and Administrative Reviews.** Program Monitoring and Administrative Reviews relate to Contractor compliance with the Agreement and Include the following:

    a. **Medical Record Review (MRR).** The Department shall review annually a selection of Participant medical records based on the number of Primary Care Providers at the Clinic Site. In addition, Contractors shall be required to maintain a Department MRR Score of eighty (80) or better for the duration of the Agreement.

    b. **Facility Site Review (FSR).** The Department shall evaluate the physical plant and operations at each Clinic Site to ensure quality standards are met in clinic facility operations Including patient access, safety, personnel and infection control. Contractors shall be expected to maintain a Health Plan and Department FSR scores of eighty (80) or better for the duration of the Agreement.

    c. **Eligibility and Enrollment Review.** The Department shall conduct monthly audits of a random sample of all new Program applications submitted through the Enrollment System to ensure data integrity, accuracy of Participant contact information, and adherence to Program rules as described in the Program Eligibility Reference Manual. The audit shall be conducted to validate, among other things, that the Contractor is compliant with Program rules, that Contractor submitted legible and appropriate verification documents to accompany the Participant's application in the Enrollment System (e.g., income, identification, assets, signed acknowledgement form, etc.) and that income information in the Enrollment System is consistent with the supporting income documentation provided by the Participant.

        If an audit/compliance review is conducted by County staff, Contractor shall have a reasonable opportunity to review County's findings prior to recoupment. If Contractor provides documentation to the County that demonstrates that any particular finding is erroneous, recoupment will not occur. The Department shall not pay, and may recoup, the MGF and, if applicable, Pharmacy MGF paid on behalf of a Participant who is found on audit or review to be ineligible for the Program and/or for whom legible and/or appropriate verification documents were not submitted.

    d. **Credentialing Review.** The Department shall review Contractor's credentialing policies to ensure that the Contractor has a well-defined credentialing and re-credentialing process for evaluating and selecting licensed independent practitioners to provide care to its patients which is compliant with State and Federal laws and regulations. This process must meet the National

Committee for Quality Assurance, Credentialing and Re-credentialing Standards, CR-1 through CR-9.

The Department shall review Contractor's compliance with all applicable Federal and State licensing requirements and supervision of non-physician medical practitioners.

e. **Medical Encounter Data.** The Department shall review all submitted medical encounter data for completeness, accuracy and compliance with formatting and submission requirements, as specified in Section III.B.4 of this Statement of Work. To the extent that the Department determines that the encounter data provided by Contractor is deficient in any of these areas, the Department shall notify Contractor in writing, (which may include notice by e-mail) of such deficiencies. Contractor shall have fourteen (14) calendar days to submit a credible plan of correction, which explains both how the deficiency will be rectified and how Contractor's processes or procedures will be modified to assure that the deficiency will not reoccur, and to resubmit corrected medical encounter data. For good cause shown, the Department may extend Contractor's time for submitting the plan of correction or resubmitting the medical encounter data. The Department may suspend payment if Contractor fails to meet the obligations of this subsection until such time as Contractor meets such obligation.

2. **Compliance Standards/Audit Response.** Contractors with deficiencies identified during the audit process may be required to submit a Corrective Action Plan (CAP) to address such deficiencies.

Categories for audit compliance scores are as follows:

Full Compliance: Means a score of ninety-five percent (95%) or above without repeat deficiencies and/or "Critical Elements, Pharmaceutical Services or Infection Control deficiencies" (as defined by the California Department of Health Care Services Medi-Cal Managed Care Division). A Contractor found to be in Full Compliance shall not be required to submit a Corrective Action Plan (CAP) to the Department.

Substantial Compliance: Means a score between eighty percent (80%) and ninety-four percent (94%), or ninety-five percent (95%) and above with repeat deficiencies and/or deficiencies in Critical Elements, Pharmaceutical Services or Infection Control. A Contractor found to be in Substantial Compliance shall be required to submit a CAP to the Department.

Non-Compliance: Means a score less than eighty percent (80%). A Contractor who is found to be in Non-Compliance shall be required to submit a CAP. Any Contractor that achieves a Non-Compliance score shall receive a follow-up focused review as an extension of the audit process to determine the depth of the identified deficiencies.

All deficiencies Including Critical Elements, Pharmaceutical Services or Infection Control deficiencies, and the Contractor's CAP, shall be tracked by the Department and analyzed for the purpose of identifying problems areas and barriers to the provision of quality health care. The Department will utilize this data to ensure that

Contractor implements solutions to identified deficiencies. The Department will provide Contractor reasonable opportunity to respond to audit findings. The CAP itself is not considered complete until the Department provides final approval and the Contractor has implemented the provisions of the CAP.

Contractor shall meet the established minimum compliance threshold for all audits conducted by the Department. If Contractor fails to implement a CAP or is non-compliant with any reasonable request related to any audit, review or finding, and/or if a Contractor has not sufficiently remedied the issues or exceptions identified by the Department, Contractor may, at the Department's discretion, be prohibited from providing Included Services to Participants until such time that the Department, at its sole discretion, has determined that the Contractor is compliant. The Contractor may not receive any of its MGF during this period. The ongoing audit process shall be outlined within each letter from DHS. These letters shall address the identified deficiencies, the actions of both Contractor and the Department and the resulting action being taken including required timelines and potential mitigation dates that may apply depending on the specifics of the audit.

3. **Financial Review**

   a. **Financial and Employment Records.** Contractor shall maintain accurate and complete employment records and financial (including billing and eligibility) records of its operations as they relate to its services under this Agreement in accordance with generally accepted accounting principles. Contractor shall retain such records for the period required by law but in any event no less than ten (10) years after date of service or five (5) years after contract termination, whichever is later. Contractor shall have their financial records audited by an independent auditor in a manner which shall satisfy the requirements of the Federal Office of Management and Budget Circular Number A-133 in accordance with Governmental Financial Auditing Standards developed by the Comptroller General of the United States, and any other applicable Federal, State, or County statutes, policies, or guidelines.

   b. **Audit/Compliance Review.** Los Angeles County staff or Federal or State Government Officials may conduct an audit/compliance review of all payments made by the County including payments and/or services provided by a subcontractor on behalf of the Contractor. If the audit is conducted by County staff, any sampling shall be determined in accordance with generally accepted auditing standards, and an exit conference shall be held following the performance of such audit/compliance review at which time the results shall be discussed with Contractor. Contractor shall be provided with a copy of any written evaluation reports prepared by County staff. If the audit/compliance review is conducted by County staff, Contractor shall have a reasonable opportunity to review County's preliminary findings for Contractor and to provide documentation to the County to demonstrate that the finding is erroneous, or that steps have been taken to correct the deficiency. If audit exceptions remain which have not been resolved to the satisfaction of the County, Contractor may be subject to a suspension in MGF payments until such time as all audit deficiencies are corrected and accepted by the County.

The County shall recoup payment due from Contractor for overpayment or improper payment of MGF, based on reconciliation or audit of enrolled Participants and eligibility, by requesting payment from Contractor, which repayment shall be remitted forthwith by Contractor to County by check made payable to the County of Los Angeles, or by withholding such amount from the usual monthly payment for Contractor's services under this Agreement as an off-set, unless any other recoupment plan is approved by County in writing.

L. **Performance Requirements Summary**

The Performance Requirements Summary (PRS) Chart, Attachment II.A to this Exhibit, lists required services that will be monitored by the County during the term of this Agreement.

1. All listings of services used in the PRS are intended to be consistent with the Agreement and the Statement of Work (SOW), and are not meant in any case to create, extend, revise, or expand any obligation of Contractor beyond that defined in the Agreement and the SOW. In any case of apparent inconsistency between services as stated in the Agreement and the SOW and Attachment II.A, PRS Chart, the language in the Agreement and then the SOW shall be given precedence. If any service seems to be created in this PRS which is not set forth in the Agreement and the SOW, that service will be null and void and place no requirement on Contractor.

2. The Contractor is expected to perform all services described herein. The PRS Chart describes certain required services which will be monitored by the County during the term of the Agreement, and for which Contractor may be assessed a suspension of payment if the service has not been satisfactorily provided. The PRS Chart indicates the SOW and/or Agreement section of the performance referenced (column 1); a description of the service to be provided (column 2); the monitoring method that will be used (column 3); and the assessment for services that are not satisfactory (column 4). Once performance requirements are satisfied, the Department will pay all suspended payments in the next payment cycle.

M. **Performance Requirements**

1. If, in the judgment of the Director, or his/her designee, the Contractor is deemed to be non-compliant with the terms and obligations assumed hereby, the Director, or his/her designee, at his/her option, in addition to, or in lieu of, other remedies provided herein, may suspend the entire MGF until such time that the performance requirements are met. A description of the work not performed, obligations not met, and whether MGF will be suspended by Department will be forwarded to the Contractor by the Director or his/her designee, in a written notice describing the reasons for said action, at least five (5) business days prior to the suspension of the MGF. If Contractor can demonstrate that its non-compliance has been remedied prior to the effective date of the suspension, such suspension shall not go into effect. When performance requirements have been satisfied, the Department will pay all suspended payments in the next payment cycle.

   If the Director, or his/her designee, determines that there are deficiencies in the performance of this Agreement that the Director, or his/her designee, deems are

correctable by the Contractor within a reasonable period of time, as determined by the Department, the Director, or his/her designee, shall provide a written notice to the Contractor to correct the deficiency within specified time frames. Should the Contractor fail to correct deficiencies within said time frame, the Director may:

(a) Suspend MGF as specified in the PRS Chart, Attachment II.A, and/or:

(b) Upon giving five (5) business days written notice to the Contractor for failure to correct the deficiencies, the County may correct any and all deficiencies and the total costs incurred by the County for completion of the work by an alternate source, whether it be County forces or separate private contractor, will be deducted and forfeited from the payment to the Contractor from the County, as determined by the County.

2. The action noted in Subsection 1.(b) above shall not be construed as a penalty, but as adjustment of payment to the Contractor to recover the County cost due to the failure of the Contractor to complete or comply with the provisions of this Agreement.

3. This Subsection shall not, in any manner, restrict or limit the County's right to damages for any breach of this Agreement provided by law or as specified in the PRS, and shall not, in any manner, restrict or limit the County's right to terminate this Agreement as agreed to herein.

ATTACHMENT I

MINIMUM SYSTEM REQUIREMENTS
for One-e-App

Attachment I sets forth the minimum System Requirements for end user hardware/software configurations and network configurations to ensure System Compatibility with personal computers, tablets and mobile devices.

1.0 MINIMUM RECOMMENDED REQUIREMENTS FOR DESKTOP/LAPTOPS:

Hardware Requirements: Computers with 512 MB RAM or higher

Software Requirements:

- PDF Reader: Adobe Acrobat Reader software to view PDF images, version 7.0 or higher;
- Pop-up Blocker: Turned off for One-e-App;
- Operating System Firewall: Turn on the firewall in the operating system. For example, built-in for Microsoft Windows operating systems;
- Antivirus Software (including antispyware software): Symantec version 12.0 or higher, McAfee version 8.8 or higher, or equivalent. Virus and spyware definitions must be updated on a regular basis.

2.0 MINIMUM RECOMMENDED INTERNET CONNECTIVITY:

Internet Connectivity: Access to high-speed internet (DSL, Cable, T1 Line) through a hard-wired or wireless router OR a broadband "air card" for portable internet connectivity.

Internet Speed: The average bandwidth availability per computer is recommended to be 3.75 Kilobytes (KB) per second to run the One-e-App.

Internet Browser: Internet Explorer version 7.0 or higher.

3.0 OTHER REQUIRED EQUIPMENT:

Printer: Dedicated or network printer with at least 600×600 dpi (dots per inch)

Scan: Scanners must be set at a minimum of 300 dpi

Signature Pads (optional): For electronic signature capturing and viewing, Signature Pad and bundles SigPlusPro software from Topaz Systems, Inc.

PERFORMANCE REQUIREMENTS SUMMARY (PRS) CHART

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
LICENSING AND CREDENTIALING			
Contractor shall ensure that all Licensing and Credentialing and Health Professional and Clinic Site Requirements are met as stated in the Statement of Work Section III.A (1-7)	**Section III.A (1)** describes the Contractor's obligation to abide by all applicable Federal and State laws, licensing requirements and locally prevailing professional health care standards of practice. **Section III.A (2-3)** describes staff supervising requirements, staffing requirements, implementation of credentialing programs, standards and guidelines, disclosure of documents relating to credentials, qualifications, and performance of its employed and contracted Health Professionals, credentialing of Health Professionals. **Section III.A (4-6)** describes handling of a suspended, revoked or restricted license, the reporting of adverse legal settlements or judgments reporting to the California Medical Board or National Practitioner Data Bank, reporting material changes in credentialing information, sanctions by Medicare or Medi-Cal certification requirements and delivery of pharmaceuticals according to evidence-based guidelines. **Section III.A (7)** describes the Contractor's obligation when providing Primary Health Care to children 21 years of age or younger.	Inspection & Observation, Verification of documentation	Contractors who do not abide by the requirements of these sections **(Section III.A, 1-7)** may, after the Department has worked in good faith with the Contractor to resolve the issues in a prompt manner, as determined by the Department, have their Monthly Grant Funding payments suspended, at the discretion of the Department, until such time as all requirements are met. Any Health Professional whose professional license is revoked, suspended or restricted in a manner that renders him or her unable to provide Program services shall not render service to Participants until the revocation, suspension or restriction has been removed or otherwise resolved.

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
REPORTING REQUIREMENTS AND PROTECTED HEALTH INFORMATION			
Contractor shall ensure that all Reporting Requirements and Protected Health Information Requirements are met as stated in the Statement of Work Section III.B (1-4) **Contractor shall participate in the Department's quality improvement initiatives and established Participant complaint procedures.**	**Section III.B (1-3)** describes the Contractor's obligation to provide the Department with a Health Professional Profile, Clinic Site and Capacity Profile, update their Open/Closed Status. **Section III.B (4)** describes the Contractor's obligation to submit Medical Encounter Data to the Department in a HIPAA compliant format.	Receipt of documentation	Contractors who have not met Reporting Requirements (Section **III.B (1-3)** in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve issues in a prompt manner, as determined by the Department, may be subject to a suspension of Monthly Grant Funding until such time as all Reporting Requirements have been received and accepted by the Department. Contractors who do not submit Medical Encounter Data **(Section III.B, 4)** shall, after the Department has worked in good faith with the Contractor to resolve the issues in a prompt manner, as determined by the Department, have their Monthly Grant Funding payments suspended, at the discretion of the Department, until such time as all Encounter Data Reporting Requirements have been

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
	Section III.B (8) describes the Contractor's obligation to provide to the Department in a timely manner an accurate count of the number of visits provided in the preceding month to Participants.		received and accepted by the Department. Contractors who do not submit Visit Information (**Section III.B, 8**) in a timely manner shall be assessed $100 per day until the Visit Information data is submitted. Said assessment amount shall be deducted from any payments owed by County to the Contractor.
PAYMENTS REQUIREMENTS			
Contractor shall meet all Payments Requirements as stated in the Statement of Work Section III.C.	**Section III.C** describes the Contractor's obligation to participate in the Medi-Cal program and remain in good standing with all requirements related to Contractor's continued participation in the Program.	Inspection & Observation Verification of documentation	Contractors who do not participate in the Medi-Cal Program and/or who do not remain in good standing with all requirements related to Contractor's continued participation in the Program., shall have their Monthly Grant Funding suspended at the discretion of the Department, until such time as all requirements related to ongoing participation in the Program have been restored.

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
ELIGIBILITY, ENROLLMENT, RE-ENROLLMENT, DIS-ENROLLMENT, OPEN/CLOSED STATUS REPORTING, AND ADDING A NEW SITE REQUIREMENTS			
Contractor shall meet all Eligibility and Enrollment, Re-Enrollment, Dis-enrollment, Open/Closed Status Reporting and Deleting and Adding New Site Requirements as stated in the Statement of Work Sections III.D – III.J.	**Section III.D** describes the Contractor's obligation to only enroll into the Program Eligible Persons, enroll and re-enroll Participants using the County's approved Enrollment System using a Qualified Enroller and at an approved Medical Home or Administrative Enrollment Site. **Section III.E** describes the Contractor's obligation to make every effort to obtain a Program renewal application from Participants and rescreen Participants for continued eligibility via the Department's Enrollment System. **Section III.F** describes the Contractor's obligation to dis-enroll Participants who no longer meet Program requirements. **Section III.G** describes the process of Participates selecting a Medical Home for Primary Health Care Services. **Section III.H** describes the process by which clinics report to the Department any changes to the open/closed status of their clinic, based on their capacity to accept new Eligible Persons and Department-referred Eligible Persons, apply a closure uniformly to all Eligible Persons, not close its practice to existing Participants, or exclude or	Inspection & Observation Verification of documentation	Contractors who do not abide by the requirements of these sections in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve issues in a prompt manner, as determined by the Department, may have their Monthly Grant Funding payments temporarily suspended until such time that requirements are met.

Specific Performance Requirement	Summary of Statement of Work Requirements	Monitoring Method	Assessment
	disadvantage Participants or advantage patients with third-party payors of financial means. **Section III.I** describes the process the Contractor must go through to delete an existing approved Clinic, Mobile Clinic or Administrative Enrollment Sites. **Section III.J** describes the process by which a clinic notifies the Department if they wish to add a new Clinic and/or transferring an approved Clinic, Mobile Clinic or Administrative Enrollment Site.		
MEDI-CAL REQUIREMENTS AND DEPARTMENTAL RECORD REVIEWS AND AUDITS			
Contractor shall meet all Medi-Cal Requirements and Departmental Record Review and Audit Requirements as stated in the Statement of Work Section III.K (1-3)	**Section III.K (1-3)** describes the Contractor's obligation to have a Medi-Cal Managed Care contract with at least one of the Health Plans in Los Angeles County, and to submit and implement all requested and required Corrective Action Plans (CAPs) that are identified by the County as part of its own annual program monitoring, administrative and financial monitoring reviews.	Inspection & Observation Verification of documentation	Contractors who do not abide by the requirements of this section in a timely and acceptable format after the Department has worked in good faith with the Contractor to resolve issues in a prompt manner, as determined by the Department, may have their Monthly Grant Funding suspended, at the Department's discretion, until such time that requirements are met.

EXHIBIT B.3
MY HEALTH LA PROGRAM
MONTHLY GRANT FUNDING, BILLING, AND ENCOUNTER DATA SUBMISSION
(Effective April 1, 2015)

1.0 Encounter Data Submission

1.1 For Included Services provided to MHLA Participants after April 1, 2015, Contractor shall submit Encounter Data to the Department, in arrears, for each office visit performed in the prior month. The encounter data shall contain the information specified from time to time by Department, but shall, at a minimum, identify each Participant receiving services and the service received.

1.2 Contractor shall submit, as directed by the Department, encounter data sixty (60) days following the end of the month that is being reported. The first medical and pharmacy encounter data submission is due on June 30, 2015, for visits that occurred in April 2015, and for every month following.

2.0 Billings

2.1 Contractor shall not bill any Participants receiving services hereunder, but may accept voluntary donations from those Participants or their families, provided that such donations are not linked to the receipt of services nor are a condition of receipt of service hereunder. In the event that Contractor determines that a Participant seeking services is eligible for services hereunder, but that the Participant requires services beyond those encompassed in this Agreement, Contractor shall be permitted to charge that Participant for any and all services rendered in accordance with Contractor's customary policies, procedures and practices pertaining to the provision of its services.

2.2 None of Contractor's physicians or other providers shall separately bill County or Participants or their families for services hereunder.

3.0. Electronic Encounter Data Submission

3.1 For Included Services provided to Participants after April 1, 2015, Contractor shall submit to Department's Claims Adjudicator data elements substantially similar to those found on the Federal Centers for Medicare and Medicaid Services Form 1500, or other forms approved by Director ("Billing Form") within sixty (60) days of the service date. Contractor shall only submit encounter data to the Department for those Participants who (a) were enrolled in the MHLA program and (b) received Included Services.

3.2 In the event that Contractor must submit corrected encounter data, or in the event that Contractor wishes to appeal a denied encounter data submission, all corrected or appealed encounter data submissions for all or any portion must be submitted to Department's Claims Adjudicator by June 30th of each year, or thirty (30) days following date of notice to Contractor that claim is rejected or denied, whichever is

later. Failure to adhere to this timeframe shall result in the denial of all the encounter data submission.

4.0 Manual Encounter Data Submission

4.1 For Included Services provided to Participants after April 1, 2015, Contractor shall submit encounter data to the Department's Claims Adjudicator manually using the Billing Form(s) completed in duplicate within sixty (60) days of the service date. All manual information must be submitted on a Billing Form, as approved by Director. Contractor shall retain one copy for its own records and shall forward the original copy to the Department's Claims Adjudicator.

4.2 In the event that Contractor must submit corrected encounter data, or in the event that Contractor wishes to appeal a denied encounter data submission, corrected or appealed encounter data submissions must be submitted to Department's Claims Adjudicator by June 30th of each year or thirty (30) days following date of notice to Contractor that the encounter data submission is rejected or denied, whichever is later. Failure to adhere to this timeframe shall result in the denial of all the encounter data submission.

5.0 Encounter Data Submission Guidelines

Contractor shall follow the encounter data submission guidelines contained in this Exhibit and as set forth in any Provider Information Notice ("PIN"), which shall be provided to Contractor as necessary according to the process set forth in this Agreement. Addresses, both electronic and U.S. mailing, for billing of County shall be provided to Contractor prior to the commencement of services hereunder through a PIN.

6.0 County's Manual Reprocessing of Contractor's Denied and Canceled Encounter Data

If encounter data submissions were denied or canceled through no fault of County or Department's Claims Adjudicator, and solely through the fault of Contractor, Contractor may, at the County's sole discretion, pay County the appropriate County contracted, per-encounter data claim fee billed to County by the Department's Claims Adjudicator. County shall not charge this fee to the Contractor in those instances where County cannot conclusively determine which party is at fault for the denial or the cancellation. Contractor shall be advised by the Director, by means of a PIN, of the current fee charged to County. The County may, at its sole discretion, recoup payment due from Contractor for denied or canceled encounter data claims by requesting payment from Contractor, which repayment shall be remitted forthwith by Contractor to County by check made payable to the County of Los Angeles, or by withholding such amount from the usual monthly payment for Contractor's services under this Agreement as an off-set, unless any other recoupment plan is approved by County in writing.

7.0 Records and Audits

Contractor shall keep clear records of the Participants served hereunder, including the service(s) provided. Contractor shall record such information on a regular basis and retain same in accordance with Paragraph 8.42, Record Retention and Inspection/Audit Settlement, of the Agreement, so that if requested, Contractor will be able to provide such

information for the duration of Agreement and for a period of ten (10) years after date of service or five (5) years after contract termination, whichever is later.

8.0 **County's Reimbursement**

8.1 For Included Services provided to Participants after April 1 2015, subject to the County's Funding, County shall pay Monthly Grant Funding in accordance with Exhibit B.2, My Health LA Program, Pricing Schedule.

8.2 Department's Claims Adjudicator and/or the Department may reconcile all payments against a Medi-Cal eligibility database before or after the processing of payment and deny payment for a Medi-Cal eligible Participant. In such event, Contractor shall receive a Remittance Advice or equivalent indicating: (a) eligible Medi-Cal denied claims, (b) other denied claims; (c) reason for denial; and (d) summary of denied claims by reason code.

8.3 Director shall have the discretion, on a periodic basis, to conduct a Medi-Cal reconciliation in which County shall reconcile some or all of the payments paid to all Contractors over the terms of their respective Agreements against a database containing the identities of all Medi-Cal eligible Participants to determine whether any Contractor has been reimbursed for services provided to Medi-Cal "eligible" Participants.

8.4 If the final Medi-Cal reconciliation process indicates that Contractor has been reimbursed for Medi-Cal eligible Participants, following Director's written notice, County may recoup any amounts owed to County by Contractor by requesting payment from Contractor, which repayment shall be remitted forthwith to County by check made payable to the County of Los Angeles, or by County withholding such amount from the usual monthly payment for Contractor's services under this Agreement as an off-set.

8.5 Notwithstanding the foregoing, if Director determines at any time that Contractor has been overpaid, the amount of the overpayment shall be either (a) credited against any amounts due by the County to Contractor or (b) paid within thirty (30) calendar days by Contractor to County, unless an alternative payment plan has been arranged by the Department on behalf of Contractor, at the Department's sole discretion.

8.6 If Director determines that Contractor has been underpaid, the amount of the underpayment shall be paid to Contractor within thirty (30) days from the date the underpayment was determined.

9.0 Submission of Encounter Data For Medical Visits in the Same Day

For Included Services provided to Participants after April 1, 2015, Contractor shall be entitled only to submit encounter data for one visit for the same Participant during the same day. Further, if County determines that Contractor has submitted encounter data to the same Participant on the same day under this Agreement, then the Department shall be entitled to cancel those encounter data claims.

EXHIBIT K-1 (or K-2)

MY HEALTH LA DENTAL CARE SERVICES
DESCRIPTION OF SERVICES
FUNDING, BILLING, AND PAYMENT
(Effective _____, 2015)

1.0 Dental Care Services

Contractor shall provide outpatient Dental Care Services for the prevention, detection, and treatment of dental problems, including dental support services, charting to dental records, and administrative management. Contractor shall bill and be paid in accordance with the State's Denti-Cal Program approved codes and published rates in effect at the time of service, except those codes that require prior authorization or are restricted. Such codes requiring prior authorizations or which are restricted are not covered by the Program except for those listed on Attachment I – MHLA Dental Approved Pre-Authorization Codes.

2.0 Dental Care Pharmacy

Contractor shall be responsible for prescribing and providing medically indicated pharmaceutical services or supplies, prescription medications, and over-the-counter medications required in conjunction with Dental Care Services. Contractor shall use the Department's approved Drug Formulary for the MHLA Program, which shall be provided to Contractor pursuant to the MHLA Agreement. Contractor may prescribe drugs beyond what is listed in the Formulary upon prior authorization from DHS, pursuant to the MHLA Agreement. Contractor may also counsel patients on non-prescription therapeutic interventions whenever feasible, for example exercise, weight loss, and smoking cessation. Contractor shall participate in all Patient Assistance Programs ("PAPs"), or assist the Department in participating in all PAPs pursuant to the MHLA Agreement.

3.0 Dental Service Sites

Contractor shall provide Dental Care Services at the Clinic Sites set forth in its Site Profile. Contractor shall inform Director in writing at least forty-five (45) calendar days prior to adding or relocating Dental Care Services at an approved Clinic Site. The addition or relocation of Dental Care Services at an approved Clinic Site may only be affected after obtaining Director's written approval. The deletion of Dental Care Services at an approved Clinic Site requires the Contractor to notify the Department consistent with Paragraph 8.38, Notices, of the Agreement at least ninety (90) days prior to the deletion of Dental Care Services at an approved Clinic Site.

4.0 Patient Eligibility and Documentation

Contractor shall provide Dental Care Services to patients who are either (a) enrolled in the MHLA program as a Participant, or (b) eligible for, but not enrolled in, the MHLA program ("Dental Participants"). Verification of the Dental Participant's eligibility shall be documented in the Dental Participant's dental record. For MHLA Participants, a print-out of the Department's Enrollment System summary sheet for the Participant ("MHLA

Summary"), which demonstrates active enrollment in the MHLA Program, shall be included in the dental record. For MHLA eligible, but not enrolled, Dental Participants, a completed Ability-to-Pay ("ATP") Application shall be included in the dental record as described in Section 6.0, Ability-to-Pay Process, herein. Such documentation must be maintained in accordance with Paragraph 8.42, Record Retention and Inspection/Audit Settlement, of the Agreement.

5.0 Program Eligibility and Renewals

5.1 Only Dental Care Services rendered to those Dental Participants who meet the eligibility requirements as described in Section 4.0, Patient Eligibility and Documentation, above, may be considered eligible for claims reimbursement under this Agreement.

5.2 Contractor shall inquire at each dental visit whether there has been any change in Los Angeles County residency, family size, health care coverage status, financial circumstances and/or any other change that could affect eligibility for the MHLA Program and/or Dental Care Services, since the patient's last visit. In the event of any such change that could affect eligibility in the MHLA Program and/or the Dental Care Services, Contractor shall be required to complete a new ATP application (for Dental Participants who are not MHLA Participants) and/or contact Member Services, or update the Dental Participant's information in the County's Enrollment System (for Dental Care patients who are MHLA Participants).

5.3 Contractor shall be responsible for ensuring that the current ATP, or MHLA Summary equivalent, is complete, valid, current and at all times physically located in the Dental Participant's dental record. In the event that Contractor maintains an electronic dental record, Contractor may scan the completed, signed, and dated ATP or the MHLA Summary equivalent into the Dental Participant's electronic dental record. Contractor shall assure that the original completed, current, signed and dated ATP is maintained in accordance with Paragraph 8.42, Record Retention and Inspection/Audit Settlement, of the Agreement.

5.4 Contractor shall re-determine, or renew, a Dental Participant's eligibility for the program at least every twelve (12) months from the date of the Dental Participant's first eligibility determination in accordance with MHLA Program requirements for redeterminations. If the Dental Participant is not a MHLA Participant, a new ATP application must be obtained every twelve (12) months and included in the Dental Participant's dental record. If the Dental Participant is a MHLA Participant, the updated MHLA Summary which demonstrates renewed coverage in the MHLA Program shall be included in the dental record. Contractor shall ensure that each Dental Participant's redetermination, whether a MHLA Participant or not, includes a screening for the enrollee's eligibility for other third-party coverage. Any Dental Participant eligible for third-party coverage shall be ineligible for the Dental Care Services, in accordance with Paragraph 2.20, Eligible Person, of the Agreement.

5.5 County shall have the ability to modify the eligibility income limit for new applicants to the Dental Care Services. County shall notify Contractor of any

modification to the income limit for the Dental Care Services through the Provider Information Notice ("PIN") process at least thirty (30) days prior to any change to the income limits taking effect.

6.0 Ability-to-Pay Application Process

6.1 Contractor shall obtain, for all patients seeking Dental Care Services under this Exhibit who are not MHLA Participants, an ATP attached hereto and incorporated herein by reference as Attachment II, as it currently exists or hereafter may be updated.

6.2 Contractor shall be notified a minimum of thirty (30) days in advance of any changes to the ATP, and of the date of availability of the revised ATP through the PIN process. The revised ATP shall be available to Contractor on the MHLA's website on the date specified in the PIN. Effective with any change(s) to the ATP, Contractor shall be responsible for ensuring that all appropriate staff are fully advised of said change(s) and shall use the revised ATP. Each revised ATP shall reflect the date of revision by the County.

6.3 To the extent the Federal Poverty Level is revised by Department of Health and Human Services, Department shall notify Contractor within five (5) business days of notice. Notice to Contractor shall occur through the PIN process.

7.0 Records and Audits

Contractor shall keep clear records of the Dental Participants served hereunder, including the Dental Care Service(s) provided. Contractor shall record such information on a regular basis and retain same in accordance with Paragraph 8.42, Record Retention and Inspection/Audit Settlement, of the Agreement, so that if requested, Contractor will be able to provide such information for the duration of Agreement and for a period of ten (10) years after date of service or five (5) years after contract termination, whichever is later.

8.0 Personnel

Prior to the commencement date of this Agreement, Contractor shall provide to Director a full listing of its then current Staff providing Dental Care Services under this Agreement, in accordance with subparagraph 9.4.10.3, Provider Roster, of the Agreement. Contractor may not add any new dentists and dental hygienists without prior written notice to Director in accordance with the Agreement. Contractor must also provide written notice to Director of any dentist that is no longer available to provide services under this Agreement within thirty (30) calendar days of the change.

9.0 Performance Improvement

Contractor shall participate in County activities to improve performance across the Dental Care Services program. As reasonable, this may include performance meetings with individual Contractors, peer review meetings, the review and development of new policies and procedures as it relates to dental care, and the provision of information, as needed.

10.0 **Clinic Capacity, Open/Closed Status for New Patients, Access Standards**

Contractors will be surveyed a maximum of twice monthly by the Department to determine whether there are any changes to the Clinic's open/closed status based on their capacity. Capacity is defined by the number of days that a new Dental Participant must wait before he or she can obtain a non-urgent Dental Care Services appointment at the Clinic Site. A Clinic Site is considered to have capacity if the Clinic Site could schedule a non-urgent Dental Care Services appointment within ninety (90) calendar days. A Clinic Site does not have capacity if the Clinic Site could not schedule a non-urgent Dental Care Services appointment within ninety (90) calendar days. A Clinic Site with capacity shall be considered "open" to new Dental Participants. A Clinic Site without capacity shall be considered "closed" to new Dental Participants.

Contractor shall make available to Dental Participants same or next day appointments for Participants whose dental condition requires them to be seen outside of a scheduled appointment.

Contractor shall inform the Department within twenty-four (24) hours if a Clinic Site no longer has the capacity to accept new Dental Participants. Contractor shall notify the Department of its intent to reopen its Clinic to new Dental Participants.

A Clinic Site's open or closed status will determine whether a Clinic Site is open to accept a referral of an Eligible Person from the Department. Any Clinic Site that is "open" to new Dental Participants must be uniformly open to Eligible Persons regardless of whether the Eligible Person presents as a walk-in or is referred from the Department. The Contractor shall not refuse to accept a Department-referred Eligible Person unless (a) the Clinic Site is "closed" to new Dental Participants, or (b) the Clinic does not have the clinical capability to care for the Eligible Person, as determined by Contractor's physician who shall attest that the Contractor does not have the clinical capability to render appropriate care to the Eligible Person. Such attestation shall be in writing, signed by the physician, include a detailed explanation as to why care cannot be rendered, and submitted to the Department within twenty-four (24) hours of the referral by the Department. The Department shall provide to Contractor the complete protocol for Patient Referral through a future PIN process.

A closure to new Eligible Persons must apply uniformly to all Eligible Persons. This means that a Clinic Site or Mobile Clinic may not be open to providing Dental Care Services to some new Eligible Persons, but not others. Clinic Sites and Mobile Clinics shall provide services to their existing Dental Participants even if they are closed to new Eligible Persons. Contractor shall not close its practice to its existing Dental Participants.

At no time shall Contractor be permitted to design or deploy programs in such a manner as to exclude or disadvantage Dental Participants or to advantage patients with third-party payors or financial means.

11.0 **Payment Rates**

Dental Care payments shall be limited only to those dental visit codes, procedures and rates established by the State of California's Denti-Cal Program on the date of service. Such codes requiring prior authorization or which are restricted are not covered by the

Program except for those listed on Attachment I – MHLA Dental Approved Pre-Authorization Codes.

12.0 **Payments Process for Fee-For-Service Compensation**

12.1 Contractor shall invoice the Department, in arrears, for each dental visit performed in the prior month. The invoices shall contain the information specified from time to time by Department, but shall, at a minimum, identify each Dental Participant receiving services, the service received, and the price of such service in accordance with those dental visit codes, procedures and rates established by the State of California's Denti-Cal Program on the date of service.

12.2 Contractor shall submit, as directed by the Department, monthly invoices to the Department by the 15th calendar day of the month following the month of service.

12.3 County Approval of Invoices. All invoices submitted by Contractor for payment must have the written approval of County's Project Manager prior to any payment thereof. In no event shall County be liable or responsible for any payment prior to such written approval. Approval for payment will not be unreasonably withheld.

12.4 Contractor's invoice shall only be approved for payment if Contractor (a) is not in default under the terms of this or any agreement with County; (b) has met all financial obligations under the terms of this and any prior agreements with County; and (c) the invoice has been received and accepted by County.

13.0 **Patient Billings**

Contractor shall not bill any Dental Participants who are receiving services hereunder, but may accept voluntary donations from those Participants or their families, provided that such donations are not linked to the receipt of services nor are a condition of receipt of service hereunder. In the event that Contractor determines that a Dental Participant is eligible for services hereunder, but that the Dental Participant requires services not provided by the Denti-Cal Program, and therefore, not reimbursable pursuant to this Agreement, Contractor shall be permitted to charge that Dental Participant for any and all services rendered in accordance with Contractor's customary policies, procedures and practices pertaining to the provision of its dental services.

14.0 **Electronic or Manual Billing**

14.1 Contractor shall submit to Department's Claims Adjudicator data elements substantially similar to those found on the dental Billing Form(s) heretofore approved by Director. Contractor shall use its best efforts to submit claims to Department's Claims Adjudicator electronically within thirty (30) days of the service date. In no event shall Contractor submit new, appealed, and corrected claims later than sixty (60) days after the service date. Claims submitted later than this timeframe will be rejected and will not be paid. Such data shall be submitted electronically for each visit provided to a Dental Participant monthly in arrears. Contractor shall not bill for Dental Care Services if the Dental Participant is eligible for Denti-Cal and/or Medi-Cal, or if the Participant has any other dental insurance of any kind.

14.2 If electronic billing between Contractor and Department's Claims Adjudicator is not operational, Contractor shall use its best efforts to submit claims to Department's Claims Adjudicator manually using the Billing Form(s) completed in duplicate within thirty (30) days of the service date. In no event shall Contractor submit new, appealed, and corrected claims later than sixty (60) days after the service date. Claims submitted later than this timeframe will be rejected and will not be paid. All manual information must be submitted on a Billing Form, as approved by Director. Contractor shall retain one billing copy for its own records and shall forward the original billing copy to the Department's Claims Adjudicator. Contractor shall not bill for Dental Care Services if the Dental Participant is eligible for Denti-Cal and/or Medi-Cal, or if the Participant has any other dental insurance of any kind.

15.0 **County's Manual Reprocessing of Contractor's Denied and Canceled Claims**

If claims were denied or canceled through no fault of County or Department's Claims Adjudicator, and solely through the fault of Contractor, Contractor shall, at the County's sole discretion, pay County the appropriate County contract, per-claim fee billed County by Department's Claims Adjudicator. County shall not charge the processing fee to the Contractor in those instances where County cannot conclusively determine which party is at fault for the denial or the cancellation. Contractor shall be advised by Director, by means of a PIN, of the current fee charged to County. The County may, at its sole discretion, recoup payment due from Contractor for denied or canceled claims by requesting payment from Contractor, which repayment shall be remitted forthwith by Contractor to County by check made payable to the County of Los Angeles, or by withholding such amount from the usual monthly payment for Contractor's services under this Agreement as an off-set.

16.0 **Billing Guidelines**

Contractor shall follow the billing guidelines contained in this Exhibit and as set forth in any PIN, which shall be provided to Contractor as necessary according to the process set forth in this Agreement. Addresses, both electronic and U.S. mailing, for billing of County shall be provided to Contractor prior to the commencement of services hereunder through a PIN.

ATTACHMENT I
MHLA Dental Approved Pre-Authorization Codes

CDT-4	DESCRIPTION
D2710	Crown-resin (indirect)
D2721	Crown-resin with predominantly base metal
D2740	Crown-porcelain/ceramic substrate
D2751	Crown-porcelain fused to predominantly base metal
D2781	Crown-3/4 cast predominantly base metal
D2791	Crown-full cast predominately base metal
D3310	Anterior (excluding final restoration)
D3320	Bicuspid (excluding final restoration)
D3330	Molar (excluding final restoration)
D4341	Periodontal scaling & root planing-4 or >contiguous teeth or bounded teeth spaces per quad
D4342	Periodontal scaling & root planing-1 to 3 teeth per quadrant
D4999	Unspecified periodontal procedure, by report
D5110	Complete denture-maxillary
D5120	Complete denture-mandibular
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	Mandiblar partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)

COUNTY OF LOS ANGELES – DEPARTMENT OF HEALTH SERVICES
COMMUNITY PARTNERS – ABILITY-TO-PAY PLAN APPLICATION
MY HEALTH LA

Name of facility taking this Application: _____

Patient: _____ **MRUN #:** _____ **Application ID #:** _____ **Member ID #:** _____

FAMILY MEMBERS IN HOME Name	BIRTHDATE Month / Day / Year	Birthplace	EMPLOYED Yes / No	Social Security Number
1 (Adult)				
2 (Adult)				
3				
4				
5				
6				

Address: _____ Telephone No.: (___)_____
Number/Street City State Zip Code

Los Angeles County Resident: Yes ☐ or No ☐

INCOME EVALUATION:

Earned Income: $ _____ Family Size: _____
+ Unearned Income: $ _____
= **Total Monthly Income** (Earned + Unearned): $_____
Is patient at or below 138% FPL? ☐ Yes or ☐ No

It has been preliminarily determined that the Total Adjusted Gross Monthly Income is at or below 138% of the Federal Poverty Level. Therefore, subject the income stated above, all outpatient services received by the patient covered by the application from _____ through _____ are with zero liability.

I/we understand and agree that this Application is made as part of the County's My Health LA Program which helps low income individuals pay for medical care.

If the patient gets or loses insurance, or if his or her family size or income changes, I/we promise to immediately report that fact to the facility where this Application was completed. I/we further agree that if I/we have any other change in financial circumstances, including but not limited to an increase in the guarantor's income, or the patient, or patient's heirs or personal representative(s) receipt of damages recovered as a result of patient's injury by accident, negligence, or wrongful act, I/we will notify the facility where this Application was completed. This Application may, at the election of the County of Los Angeles, be terminated.

Pursuant to Section 360.5 of the California Code of Civil Procedure, which allows written waivers related to actions for the repayment of County aid, I/we agree that all statutes of limitation upon all debts related to the health care services covered by this Application are hereby waived. This Application shall not in any way diminish or defeat the County's rights which may exist under California Government Code sections 23004.1 and 23004.2, or the Hospital Lien Act, or any other applicable laws, to recover reimbursement from any responsible third-parties, including tortfeasors, the reasonable charges for health care services provided to the patient.

I/WE CERTIFY UNDER PENALTY OF PERJURY BY MY/OUR SIGNATURE(S) THAT THE INFORMATION I/WE HAVE PROVIDED AS REQUESTED IN THIS AGREEMENT IS TRUE AND COMPLETE TO THE BEST OF MY/OUR KNOWLEDGE AND BELIEF. I/WE ALSO CERTIFY BY MY/OUR SIGNATURES THAT I/WE HAVE READ AND UNDERSTAND ALL THE FORGOING AND THAT I/WE AGREE TO SIGN THIS STATEMENT WITHOUT ANY RESERVATION WHATSOEVER.

_____ _____ _____ _____
Patient's Signature Date Interviewer's Signature Date

_____ _____
Responsible Relative Signature Date

(LGuzman\ATP\CP ATP Income & Service Agreement 03-26-15)

COUNTY OF LOS ANGELES - DEPARTMENT OF HEALTH SERVICES
COMMUNITY PARTNERS
ABILITY-TO-PAY PLAN APPLICATION – MY HEALTH LA
138% FEDERAL POVERTY LEVEL

(Effective April 1, 2015 through March 31, 2016)

FAMILY MEMBERS LIVING IN THE HOME [1]	TOTAL MONTHLY INCOME MAXIMUM [2]
☐ 1	at or below $ 1,354
☐ 2	at or below $ 1,832
☐ 3	at or below $ 2,311
☐ 4	at or below $ 2,789
☐ 5	at or below $ 3,268
☐ 6	at or below $ 3,746
☐ 7	at or below $ 4,224
☐ 8	at or below $ 4,703
☐ 9	at or below $ 5,181
☐ 10	at or below $ 5,660
☐ 11	at or below $ 6,138
☐ 12	at or below $ 6,616
More than 12 Members	For each additional member, add $ 479

[1] Include unborn in family size.

[2] For ATP, all deductions are eliminated:

- $90 per working person.
- Child Care
- Medical Insurance expenses, and
- Alimony/Child Support Paid

(sdavda\ACNRequests\FPL138-.6-15)

MY HEALTH LA (MHLA) INCOME CALCULATION WORKSHEET
(To be Completed by Interviewer - PLEASE PRINT)
VALID FROM 04/01/2015 THROUGH 03/31/2016

Patient Name: _____ Date of Application _____

PART A: INCOME INFORMATION

1. Patient has **(Check one box):** ○ Zero liability ORSA/ATP ○ CP - ATP

2. Grand Total Monthly Net Income - [Enter from Worksheet, Part B, Line 6] $ _____ -

3. Number of family members in household? _____ 138% FPL for household _____

4. **MHLA ELIGIBLE?** ◉ Yes ○ No **IF YES, ELIGIBILITY PERIOD FROM** _____ **THROUGH** _____

PART B: INCOME SOURCE

☑ Employed ☑ Self-Employed ☑ DIB ☐ In-kind Income ☐ Social Security ☐ Retirement/Other Pension

☐ Cash Contribution ☐ Child Support/Alimony Received ☐ UIB ☐ Net Rental Income ☐ Other (Specify) _____

[Show only one source of income per person. If individual has more than one type of income, use addt'l Income Calculation Worksheet]

EARNED INCOME SOURCE:

1. Applicant _____
Gross Earnings (Per Pay Period) _____ X (4.33, 2.167, 2, 1) = $ _____
◉ Weekly ○ Bi-Weekly ○ Semi-Monthly ○ Monthly

2. Spouse/Parent _____
Gross Earnings (Per Pay Period) _____ X (4.33, 2.167, 2, 1) = $ _____
○ Weekly ○ Bi-Weekly ◉ Semi-Monthly ○ Monthly

3. Child(ren): Name _____
Gross Earnings (Per Pay Period) _____ X (4.33, 2.167, 2, 1) = $ _____
○ Weekly ○ Bi-Weekly ○ Semi-Monthly ◉ Monthly

4. Self Employed ○ **Yes** ◉ No If Yes, **MONTHLY NET** Profit _____ $ _____
◉ Fluctuating ○ Non-Fluctuating

UNEARNED INCOME SOURCE:

5. Name _____ Income Source: _____
Gross Earnings (Per Pay Period) _____ X (4.33, 2.167, 2, 1) = $ _____
◉ Weekly ○ Bi-Weekly ○ Semi-Monthly ○ Monthly

6. **TOTAL NET NONEXEMPT INCOME (Add lines 1-5)** $ _____

7. **Is Total Net Nonexempt Income at or Below 138% FPL? (See Part A, Line 3)** ○ Yes ◉ No

Imprint Clinic ID Card

FORM VALID UNTIL 03/31/2016

EXHIBIT II

Agreement No. H-706240-3

DENTAL CARE SERVICES

AMENDMENT NO. 3

THIS AMENDMENT is made and entered into this _____ day of _____, 2015,

by and between COUNTY OF LOS ANGELES (hereafter "County"),

and CHILDREN'S DENTAL FOUNDATION (hereafter "Contractor").

WHEREAS, reference is made to that certain document entitled "DENTAL CARE SERVICES", dated October 24, 2014, and any amendments thereto, all further identified as Agreement No. H-706240 (all hereafter "Agreement"); and

WHEREAS, it is the intent of the parties to amend the Agreement to make programmatic and administrative changes needed for the continued implementation of the My Health LA Program; and

WHEREAS, County desires to address these necessary changes by making revisions to Agreement Paragraph 2.0, Definitions, and Paragraph 5.0, Billing and Payment, and adding Exhibit B.1; and

WHEREAS, the Agreement provides that changes to its terms may be made in the form of a written amendment which is formally approved and executed by the parties.

NOW, THEREFORE, the parties hereby agree as follows:

1. This Amendment shall be effective upon execution.

2. Agreement Paragraph 2.0, Definitions, subparagraph 2.13, Dental Care Services, is hereby deleted in its entirety and replaced as follows:

"2.0 DEFINITIONS

2.13 Dental Care Services means medically necessary and preventive outpatient dental care services for the prevention, detection, and treatment of dental problems and includes dental support services, charting to dental records, administrative management and pharmaceutical services or supplies, prescription medications and over the counter medications

required in conjunction with Dental Care Services. Dental Care Services shall be limited only to those dental visit codes and procedures allowed by the State of California's Denti-Cal Program on the date of service, except those codes which require prior authorization or are restricted. Such codes requiring prior authorizations or which are restricted are not covered by the Program except for those listed on Exhibit B-1, Billing and Payment - Attachment 1."

3. Agreement Paragraph 2.0, Definitions, subparagraph 2.17, Eligible Person, is hereby deleted in its entirety and replaced as follows:

"2.0 DEFINITIONS

2.17 Eligible Person is defined as a person who meets all of the following:

a. Has been deemed ineligible for local, State and Federal full-scope (share of cost and no-share of cost) government healthcare program based on data entered by Contractor's Staff in the Enrollment System, or has provided written proof of denial (excluding denials related to failure to cooperate) from other state and Federal full-scope programs, which denial is dated within the thirty (30) days prior to the person's submission of an application to participate in the MHLA Program.

b. Lacks health insurance (i.e. is uninsured). Individuals with restricted or limited scope Medi-Cal may be considered eligible for services not covered under restricted or limited scope Medi-Cal.

c. Is a current Los Angeles County resident, with proof of Los Angeles County residency, and does not have an active I-94 form (i.e. is a refugee, is an asylee, or possesses a certification letter from the Office of Refugee Resettlement). Homeless applicants may provide verbal proof of Los Angeles County residency. An Eligible Person's family member who is a student attending school outside of Los Angeles County is considered a Los Angeles County resident if the student (1) is claimed as a dependent on the most recent Federal and State tax returns filed on behalf of a Los Angeles County resident, and (2) lives at least part of the year in Los Angeles County for any year in which he or she seeks participation in the MHLA Program.

d. Is age 6 or older (inclusive) until such time that the State of California implements Section 14007.2 of the Welfare and Institutions Code, at which time is age 19 or older (inclusive). An emancipated minor may apply for coverage on his or her own behalf if he or she is not living in the home of a birth or adoptive parent, a legal guardian, caretaker relative, foster parent, or stepparent.

e. Has a household income at or below 138 percent of the Federal Poverty Level published by the U.S. Department of Health and Human Services. The pre-tax income calculation shall include all earned and unearned taxable income, as well as realized earnings from non-retirement-related liquid assets (i.e., dividends paid in an investment account)."

4. Agreement Paragraph 5.0 – BILLING AND PAYMENT, is hereby deleted in its entirety and replaced as follows:

5.0 BILLING AND PAYMENT

5.1 The Contractor shall be paid a set fee for each Dental Participant visit for Dental Care Services and Dental Care Pharmacy as specified in Exhibit B-1 – Billing and Payment.

5.2 No Payment for Services Provided Following Expiration/ Termination of Agreement

The Contractor shall have no claim against County for payment of any money or reimbursement, of any kind whatsoever, for any service provided by the Contractor after the expiration or other termination of this Agreement. Should the Contractor receive any such payment it shall immediately notify County and shall immediately repay all such funds to County. Payment by County for services rendered after expiration/termination of this Agreement shall not constitute a waiver of County's right to recover such payment from the Contractor. This provision shall survive the expiration or other termination of this Agreement.

5.3 Invoices and Payments

The Contractor shall invoice County and be paid in accordance with Exhibit B-1 – Billing and Payment."

5. Agreement Exhibit B.1 – DENTAL CARE SERVICES, BILLING, AND PAYMENT, shall be added to the Agreement, attached hereto and incorporated herein by reference.

6. Except for the changes set forth hereinabove, Agreement shall not be changed in any other respect by this Amendment.

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IN WITNESS WHEREOF, the Board of Supervisors of the County of Los Angeles has caused this Amendment to be executed by its Director of Health Services, and Contractor has caused this Amendment to be executed in its behalf by its duly authorized officer, the day, month, and year first above written.

COUNTY OF LOS ANGELES

By_____
Mitchell H. Katz, M.D.
Director of Health Services

CHILDREN'S DENTAL FOUNDATION
Contractor

By_____
Signature

_____
Printed Name

Title_____
(AFFIX CORPORATE SEAL)

APPROVED AS TO FORM
Mary C. Wickham
Interim County Counsel

BY _____
Senior Deputy County Counsel

EXHIBIT B-1

DENTAL CARE SERVICES
BILLING AND PAYMENT
(Effective _____, 2015)

1.0 Payment Rates

Dental Care payments shall be limited only to those dental visit codes, procedures and rates established by the State of California's Denti-Cal Program on the date of service. Such codes requiring prior authorization or which are restricted are not covered by the Program except for those listed on Attachment I – Dental Care Services, Approved Pre-Authorization Codes.

2.0 Payments Process for Fee-For-Service Compensation

2.1 Contractor shall invoice the Department, in arrears, for each dental visit performed in the prior month. The invoices shall contain the information specified from time to time by Department, but shall, at a minimum, identify each Dental Participant receiving services, the service received, and the price of such service in accordance with those dental visit codes, procedures and rates established by the State of California's Denti-Cal Program on the date of service.

2.2 Contractor shall submit, as directed by the Department, monthly invoices to the Department by the 15th calendar day of the month following the month of service.

2.3 County Approval of Invoices. All invoices submitted by Contractor for payment must have the written approval of County's Project Manager prior to any payment thereof. In no event shall County be liable or responsible for any payment prior to such written approval. Approval for payment will not be unreasonably withheld.

2.4 Contractor's invoice shall only be approved for payment if Contractor a) is not in default under the terms of this or any agreement with County; b) has met all financial obligations under the terms of this and any prior agreements with County; and c) the invoice has been received and accepted by County.

3.0 Patient Billings

Contractor shall not bill any Dental Participants who are receiving services hereunder, but may accept voluntary donations from those Participants or their families, provided that such donations are not linked to the receipt of services nor are a condition of receipt of service hereunder. In the event that Contractor determines that a Dental Participant is eligible for services hereunder, but that the Dental Participant requires services not provided by the Denti-Cal Program, and therefore, not reimbursable pursuant to this Agreement, Contractor shall be permitted to charge that Dental Participant for any and all services rendered in accordance with Contractor's customary policies, procedures and practices pertaining to the provision of its dental services.

4.0 **Electronic or Manual Billing**

4.1 Contractor shall submit to Department's Claims Adjudicator data elements substantially similar to those found on the dental Billing Form(s) heretofore approved by Director. Contractor shall use its best efforts to submit claims to Department's Claims Adjudicator electronically within thirty (30) days of the service date. In no event shall Contractor submit new, appealed, and corrected claims later than sixty (60) days after the service date. Claims submitted later than this timeframe will be rejected and will not be paid. Such data shall be submitted electronically for each visit provided to a Dental Participant monthly in arrears. Contractor shall not bill for Dental Care Services if the Dental Participant is eligible for Denti-Cal and/or Medi-Cal, or if the Participant has any other dental insurance of any kind.

4.2 If electronic billing between Contractor and Department's Claims Adjudicator is not operational, Contractor shall use its best efforts to submit claims to Department's Claims Adjudicator manually using the Billing Form(s) completed in duplicate within thirty (30) days of the service date. In no event shall Contractor submit new, appealed, and corrected claims later than sixty (60) days after the service date. Claims submitted later than this timeframe will be rejected and will not be paid. All manual information must be submitted on a Billing Form, as approved by Director. Contractor shall retain one billing copy for its own records and shall forward the original billing copy to the Department's Claims Adjudicator. Contractor shall not bill for Dental Care Services if the Dental Participant is eligible for Denti-Cal and/or Medi-Cal, or if the Participant has any other dental insurance of any kind.

5.0 **County's Manual Reprocessing of Contractor's Denied and Canceled Claims**

If claims were denied or canceled through no fault of County or Department's Claims Adjudicator, and solely through the fault of Contractor, Contractor shall, at County's sole discretion, pay County the appropriate County contract, per-claim fee billed County by Department's Claims Adjudicator. County shall not charge the processing fee to the Contractor in those instances where County cannot conclusively determine which party is at fault for the denial or the cancellation. Contractor shall be advised by Director, by means of a PIN, of the current fee charged to County. The County may, at its sole discretion, recoup payment due from Contractor for denied or canceled claims by requesting payment from Contractor, which repayment shall be remitted forthwith by Contractor to County by check made payable to the County of Los Angeles, or by withholding such amount from the usual monthly payment for Contractor's services under this Agreement as an off-set.

6.0 **Billing Guidelines**

Contractor shall follow the billing guidelines contained in this Exhibit and as set forth in any PIN, which shall be provided to Contractor as necessary according to the process set forth in this Agreement. Addresses, both electronic and U.S. mailing, for billing of County shall be provided to Contractor prior to the commencement of services hereunder through a PIN.

ATTACHMENT 1
Dental Care Services
Approved Pre-Authorization Codes

CDT-4	DESCRIPTION
D2710	Crown-resin (indirect)
D2721	Crown-resin with predominantly base metal
D2740	Crown-porcelain/ceramic substrate
D2751	Crown-porcelain fused to predominantly base metal
D2781	Crown-3/4 cast predominantly base metal
D2791	Crown-full cast predominately base metal
D3310	Anterior (excluding final restoration)
D3320	Bicuspid (excluding final restoration)
D3330	Molar (excluding final restoration)
D4341	Periodontal scaling & root planing-4 or >contiguous teeth or bounded teeth spaces per quad
D4342	Periodontal scaling & root planing-1 to 3 teeth per quadrant
D4999	Unspecified periodontal procedure, by report
D5110	Complete denture-maxillary
D5120	Complete denture-mandibular
D5211	Maxillary partial denture-resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
D5212	Mandibular partial denture-resin base (including any conventional clasps, rests and teeth)
D5213	Maxillary partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)
D5214	Mandiblar partial denture-cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)